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Patients Name ____________________
(Print)

Date Of Birth ____________________

Psychiatric History

Reason for your current visit ____
How long have you had this problem?____
Have you seen a Psychiatrist before? Y or N
If "Yes" what is their name ____
Do you have a Psychologist or Therapist? Y or N
If "Yes" what is their name ____
May I contact your Therapist if necessary? Y or N
Who referred you to this office? ____

Past History

Did you have any behavioral problems as a child or teenager? Y or N
Did you see a Psychiatrist as a child? Y or N
Did you take medications for a mental illness as a child or teenager? Y or N
If "Yes" what were the medications prescribed ______________________________

Have you ever been diagnosed with a learning disability? Y or N
If "Yes" what kind of learning disability __________________________________

Were you abused in your childhood or young adulthood?
Physically **Mentally** **Sexually** **N/A**

Do you have a history of psychiatric hospitalizations? Y or N
If "Yes":

1.Hospital Name ____________________ Reason ________________ Date ________
2.Hospital Name ____________________ Reason ________________ Date ________
3.Hospital Name ____________________ Reason ________________ Date ________

Have you ever attempted suicide? Y or N

If "Yes" how many times ____________________

Did your suicide attempt require an: **ER Visit** **ICU** **Psychiatric Hospitalization**

When was the last time you attempted suicide? ____________________

When was the last time you were thinking about suicide? ____________________

Do you have suicide thoughts now? Y or N

Have you ever had homicidal thoughts? Y or N

Have you ever hurt someone physically? Y or N

Are you thinking of hurting someone now? Y or N

Have you been violent or aggressive? Y or N

Check your current stressors:

Marital Problems ____

Parent-Child Issues ____

Break-up of relationship ____

Death in family/close friend ____

Personal Health Problems ____

Retired, Job loss or change ____

Legal or Financial problems ____

Describe stressor:

____

____

Are you planning to apply for disability? Y or N

If "Yes" **Short-term** **or** **Long-term**

Substance Use History

How much alcohol do you drink and how often: ____________________

Are you a recovering alcoholic? Y or N

Have you ever used **Illicit Drugs** or abused **Prescription Medications**? Y or N

If "Yes" check all that apply:

Marijuana ____

Amphetamine/Speed ____

Heroine/Opioids ____

LSD/Hallucinogens ____

Cocaine/Crack ____

Barbiturates/Sedatives ____

PCP ____

What is your drug of choice? ____________________

When was the last time you used drugs? ____________________

Do you smoke cigarettes? Y or N
If "Yes" how long have you been smoking and how much ______________________________

Do you drink caffeinated beverages? Y or N
If "Yes" what kind and how much ____

Symptom Screening (circle all that apply)

Fears
Phobias
Obsessive thoughts
Compulsive actions
Depressed mood/feeling sad
Impulsive eating
Purging
Excessive dieting
Severe weight loss
Elevated, ecstatic mood
Severe mood swings
Not sleeping for days
Sexually promiscuous behavior
Speeding tickets
History of cutting yourself
Aggressive and violent
Frequently lying to family/friends
Frequently changing jobs
Frequently waking up at night
Snore at night
Frequently take naps during the day
Falling asleep while driving
Paranoid feelings
Hearing voices
Having "visions"
Lapses of Memory

Family History

Mother	Psychiatric Problems ______________________________
	Suicide/Attempts ______________________________
	Drug/Alcohol Abuse ______________________________
Father	Psychiatric Problems ______________________________
	Suicide/Attempts ______________________________
	Drug/Alcohol Abuse ______________________________
Grandparents/ Uncles/Aunts	Psychiatric Problems ______________________________
	Suicide/Attempts ______________________________
	Drug/Alcohol Abuse ______________________________
Children	Psychiatric Problems ______________________________
	Suicide/Attempts ______________________________
	Drug/Alcohol Abuse ______________________________

Medical History

Chronic Illnesses ____

Any Surgeries in the past ____

Currently sexually active? Y or N

Practicing safe sex? Y or N

For females only:

Last Menstrual Period date ________________ ***Regular? Y or N***

Using Contraceptives? Y or N

If "Yes" what kind ____

Social History

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____

Do you have children? Y or N

If "Yes" how many ____________

Educational Background:

HS Diploma ____ Some College _____ Under Grad _____ Post Grad _____ Doctorate _____

Occupation/Employer____

CURRENT MEDICATIONS:

____

____

OVER THE COUNTER MEDS:

____

HERBAL AND FOOD SUPPLEMENTS:

____

ALLERGIES:

____

PSYCHIATRIC MEDICATIONS TRIED IN THE PAST:

____

____

Anything important that you think I need to know about you and did not ask?

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