Psychiatric and Medical History

First name:_____ Middle Initial: ____ Last Name:_____

Current problems or reason for seeking help? _____

_____

_____

_____

Average hours of sleep a night: _____

Physical Activity (type and frequency): _____

Amount of time spent outdoors a day:_____

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Typical Snacks: _____

Ways you relax or handle with stress?_____

How often do you talk with friends or family? _____

Previous psychiatric diagnoses: _____

_____

History of harming self or others. If yes, please explain: _____

_____

Current thoughts of hurting self or others? _____

Inpatient psychiatric care: If yes, when and why? _____

_____

Receiving therapy currently? If yes, by who? _____

Previous psychiatrists/therapists/psychologists:
Name: Dates seen: Reason:

_____

_____

Previous psychotropic medications:
Names : Dates: Reason: Effect:

_____

_____

_____

_____

_____

Please estimate amount and frequency:

Nicotine use: _____ Alcohol use: _____

Cannabis use:_____

Opiates (hydrocodone, oxycodone, heroin, fentanyl, kratom, tramadol) use:

_____

Cocaine use:_____ Amphetamine use: _____

Benzodiazepine (Xanax, Valium, Klonopin, Ativan, Ambien, Lunesta, etc) use: _____

_____

Current medical conditions:_____

_____

_____

History of seizures, head injuries, or loss of consciousness? If yes, please explain:

_____

Current medications:

_____

_____

_____

_____

Allergies:_____

Last time lab work was done: _____

Primary Care Physician: _____

Living situation:_____

Pending legal charges or disability claims. If yes, please explain: _____

_____

Do you want any information disclosed to your health insurance for purposes of prior authorization of medications? _____

_____

_____

The above information is true to the best of my knowledge.

Print Name:_____

Signature: _____ Date:_____