

Siblings (Include names, ages/marital status/occupation/nieces or nephews) _____

Please list referral source:

_____ **Referral Source** _____ **Phone Number of Referral Source**

EMERGENCY CONTACT

Name _____ **Relationship to you** _____

Daytime Phone: _____ **Cell Phone** _____

Evening Phone _____

**Answer the following with respect to the symptoms that bring you here today.
IF "1" IS THE WORST YOU EVER FELT AND "10" IS THE BEST, WHERE ARE YOU TODAY?**

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Describe the reason for this visit and the symptoms that you are currently experiencing.

Describe when your current symptoms began and if they have changed over time.

Are you currently in psychotherapy? Yes _____ No _____

If yes, how long have you been in treatment with your current therapist? _____

If yes, what is the name and phone number of your therapist?

Name _____ Phone Number _____

List all Medications you are currently taking:

	DRUG	DOSE	START DATE
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____

What are the names and phone numbers of the physicians who are prescribing the medications?

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

Please describe if there are side effects (even if you are not sure if they are side effects):

List past psychiatric medications and how you responded to them:

List past psychiatric or other treatments for psychiatric symptoms and dates of treatment:

Have you ever been hospitalized for a psychiatric illness? If yes, list the hospitals and dates of admission and discharge.

Do you drink? Yes _____ No _____ Specify number of glasses or bottles per week. _____

Please specify where beer, hard liquor or wine. _____

Do you use Motrin, Advil, Aleve, Ibuprofen or other drugs for pain or inflammations?

Yes _____ No _____ Which ones? _____.

MEDICAL HISTORY

Primary Care Physician _____ Phone Number _____

Address _____ Date of most recent Physical Exam. _____

Have you ever been treated for any of the following?	Yes	No	Has anyone in your family ever been treated for the following? Please check yes and describe below.	Yes	No
Heart Disease					
High Blood Pressure					
Stroke					
Diabetes					
Arthritis					
Parkinson's					
Cataracts/other eye problems					
Glaucoma					
Hearing Problems					
Lung Disease					
Skin Diseases					
Urinary Tract Infections					
Gastro-Intestinal Problems					
Growths/ Cancer					
Hospitalizations					
Major Operations					
Sexually Transmitted Diseases					
Kidney Disease					
Liver Disease					
Gynecologic Problems					
Psychiatric Disorders					

Have you had?	Yes	No	Has anyone in your family had the following? Please check yes and describe below.	Yes	No
Blackouts					
Convulsions or Seizures					
Headaches					
Tremors					
Dizziness					
Forgetfulness					
Major Weight Loss/ Gain					

Do you have a history of the following?	Yes	No	Does anyone in your family have a history of the following, Please check yes and describe below	Yes	No
Drug Abuse					
Alcohol Abuse					

Briefly describe any current medical problems. _____

Briefly describe any unusual childhood illnesses: (please give age) _____

Briefly describe any serious adult illnesses: (please give approx. age) _____

Briefly describe any hospitalizations or surgeries _____

For women of child bearing age, please record date of last menstrual period: _____