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PATIENT INFORMATION FORM

GENERAL INFORMATION

Full Name: _____

Date Completed: _____ Occupation: _____

Birth Date: _____ Social Security Number: _____

Mailing address: _____

City, State, Zip Code: _____

Residence address (if different): _____

City, State, Zip Code: _____

Phone 1 (home/work/cell?): _____ Ok to leave message? _____

Phone 2 (home/work/cell?): _____ Ok to leave message? _____

E-mail address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Relationship to you: _____

Referred by: _____

Educational History: _____

_____

_____

_____

What brings you to treatment at this time? _____

_____

_____

_____

Client name: _____ Date of Birth: _____

PSYCHIATRIC HISTORY

Prior outpatient mental health providers (psychiatrists, psychotherapists, counselors) ☐ **None**

Provider Name	Begin Date	Ending Date	Services Provided	Outcomes	Reason(s) for Stopping

Psychiatric Medication History (Current and Past) ☐ **None**

Medication Name	Date Started	Date Stopped	Dose and Frequency	Condition Being Treated	Prescribing Provider	Response/Side Effects

Psychiatric Hospitalizations ☐ **None**

Facility Name and Location	Begin Date	Ending Date	Reason for Hospitalization	Outcomes	Voluntary or Involuntary?

Allergies to Medications (with type of reaction): _____

_____

_____

Prior psychiatric diagnoses: _____

_____

_____

Any history of law-breaking behavior? ☐ Yes ☐ No IF YES – specify details of arrest, detention, diversion, probation, etc : _____

_____

_____

Client name: _____ Date of Birth: _____

SUBSTANCE USE HISTORY

How many times a week do you drink alcohol?

☐ None (If none, why not? _____)

☐ less than once a week ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5 or more times a week

How much do you usually drink at a sitting: ☐ 1 drink ☐ 2-3 drinks ☐ 4-5 drinks ☐ more: _____

Do you use cannabis/marijuana? ☐ Yes ☐ No If so, how often?

☐ less than once a week ☐ 1-2 times a week ☐ 3-4 times a week ☐ 5 or more times a week

What other drugs do you use currently? How frequently?_____

_____

_____

_____

Have you used any other drugs in the past? _____

_____

_____

_____

_____

Are you currently in treatment or recovery? ☐ Yes ☐ No

Treatment history (include facilities, dates, history of AA or 12-step involvement):_____

_____

_____

_____

_____

Do you currently feel that drugs or alcohol are a problem for you? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

Client name: _____ Date of Birth: _____

MEDICAL HISTORY

Primary Care Provider (Name, Location, and Phone Number): _____

_____

_____

Current and Past Medical Conditions: _____

_____

_____

Current Non-Psychiatric Medications			☐ **None**
Medication Name	Dose and Frequency	Condition(s) Being Treated	Prescribing Provider

Medical (Non-Psychiatric) Hospitalizations and Surgeries				☐ **None**
Facility Name and Location	Begin Date	Ending Date	Reason for Hospitalization	Outcomes

Have you ever had a seizure? ☐ Yes ☐ No

IF YES – specify onset date, type, duration, and date of last EEG: _____

_____

_____

_____

Have you ever had any serious head injuries? ☐ Yes ☐ No

IF YES – specify dates, medical evaluation results, and whether or not you lost consciousness: _____

_____

_____

_____

Client name: _____ Date of Birth: _____

REVIEW OF SYSTEMS

Any current problems with…	IF YES, please explain:
☐ recurrent headaches	
☐ vision problems	
☐ hearing problems	
☐ recurrent infections	
☐ recurrent respiratory problems	
☐ recurrent nausea/diarrhea/constipation	
☐ bladder or urination problems	
☐ significant weight loss or gain	
☐ skin problems	
☐ problems with bones, muscles or joints	
☐ tremor, shakes or jitters	
☐ tics or other movement problems	
☐ sexual dysfunction or problems	
☐ other problems	

Any pain issues or concerns? ☐ Yes ☐ No

IF YES – please describe :_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

Are there any mental health, psychiatric, or substance abuse issues in your immediate family members (mother, father, siblings, children?) _____

_____

_____

_____

Any in your non-immediate family? _____

_____

_____

_____

OTHER

Do you own any guns? ☐ Yes ☐ No If so, how are they stored? _____

_____

How is the ammunition stored? _____

_____

Client name: _____ Date of Birth: _____

INSURANCE INFORMATION

Insurance Plan Name: _____

Insured Member Name: _____

Member ID Number: _____

Group Number: _____

Plan Phone Number: _____

Pharmacy Plan Name: _____

Pharmacy Member ID Number: _____

Pharmacy Plan Phone Number: _____

Pharmacy Plan Fax Number: _____

Local Pharmacy Name: _____

Local Pharmacy Location: _____

Local Pharmacy Phone Number: _____

Local Pharmacy Fax Number: _____

OTHER INFORMATION

What do you hope to gain from treatment? _____

Is there other information that you feel I should know? _____