

Patient:

DOB:

Date Completed:

Form Version Mar. '26

**Completion and submission of this form does not establish or guarantee a patient-physician relationship; it is a screening tool to determine if our practice is the right fit for your needs. Extra space is available on the last page.**

**Psychiatric History Record**

Date completed:

Completed by:

Relation to patient:

**Full legal name:**

Sex: Male

Female **DOB:**

**Mailing address:**

City:

ZIP:

**Email address:**

**Phone number:**

Family physician:

Referred by:

Employer:

Since:

Job title:

Name of significant other:

DOB:

Significant other's employer:

Since:

Job title:

**Treatment Motivation:**

Self-initiated

Encouraged by spouse or family member

Mandated (legal/probation/employer)

**Identify what you consider your main psychiatric concern at present:**

List ALL medications and supplements you take currently (name, dosage, frequency, indication):

Medication Name

Dosage (in mg)

How Often/When Taken?

What Condition Taken For?

**Medical History**

Height:    ft    in    Weight:    lbs    Any significant (>10 lbs) weight change in the past year?

Explain the weight change, if applicable:

List ALL of your medication allergies, and describe the reaction you experience:

List ALL of your current medical conditions, including any heart, liver, kidney, neuro conditions:

Do you have a medical history of the following: (indicate "No" or "Yes" for each)

Diabetes:	No	Yes	High Blood Sugar:	No	Yes
High Cholesterol:	No	Yes	Heart Disease:	No	Yes
High Blood Pressure:	No	Yes	Stroke:	No	Yes
Seizures:	No	Yes	Traumatic Brain Injury:	No	Yes
Obesity:	No	Yes			

List ALL hospitalizations in the past 10 years (providing information regarding years, locations, reasons, durations):

Any other surgery or major illness or injury in your past? Provide additional information, as needed:

List ALL physicians who have diagnosed or treated you in the past year, their locations and their specialties:

Approximate date of last physical examination:

Have you been experiencing any unexplained medical symptoms? If so, please describe:

**Review of Systems Summary:** Mark each symptom that you are experiencing currently/recently:

- Neuro:            Severe headaches            Vision changes            Numbness/Tingling/Weakness
- Difficulty walking            Seizures/Passing out episodes            Memory loss/Trouble remembering
- Endocrine:       Rapid weight loss/gain            Unexpected fatigue/lethargy            Neck swelling
- Heat/cold intolerance            Excessive thirst/Frequent urination            Hair loss/Skin changes
- Cardio/Pulm:     Chest pain/discomfort            Palpitations/Fast heartbeat with dizziness/fainting
- Shortness of breath at rest/with mild activity            Leg/ankle swelling            Persistent/bloody cough
- GI:                Severe/persistent abdominal pain            Severe diarrhea/constipation
- Persistent nausea/vomiting            Yellowing of skin/eyes            Unexpected weight loss
- Autoimmune/Infectious:       Fever with confusion/stiff neck            Severe joint pain with redness/swelling
- Other:            Tremor/shaking in hands/body            Excessive daytime sleepiness/loud snoring
- Involuntary movements in face/mouth/body            Urinary issues (including retention)

**Mental Health History**

Any previous psychiatric treatment?            Never            Previous psychiatric treatment:  
 If so, please provide the following information for each provider and/or acute episode: MM/YYYY-MM/YYYY, name of the provider, the reason for seeking care, the reason for discontinuing treatment:

Any previous/current talk therapy/counseling?            Never            Previous/current therapy:  
 If so, please provide the following information for each provider and/or acute episode: MM/YYYY-MM/YYYY, name of the provider, the reason for seeking care, the reason for discontinuing treatment:

List any previous psychiatric diagnoses, when the diagnosis was made, and by whom:

Have you ever undergone psychological testing?            Never            I have undergone testing:  
 If so, please provide the following information for each encounter: MM/YYYY, the reason for the testing, the administering provider, the outcome/findings:

**Mental Health History (Continued)**

Have you ever been hospitalized for psychiatric reasons?      Never      Previous hospitalization:

If so, please provide the following information for each hospital stay: MM/YYYY, the length of the stay, the name of the hospital & location, and the reason for the psychiatric hospitalization:

Have you ever attempted suicide?      Never      I have previously attempted suicide:

If so, please provide the following information regarding each attempt: MM/YYYY, method. Also, please briefly describe what was happening in your life at the time of the attempt:

**\*\*\*Important: If You Are Currently Experiencing Suicidal Thoughts, Do NOT Continue to Fill Out This Form. Call #988, #911, Or Go Directly To The Emergency Department . \*\*\***

Have you ever harmed yourself purposely, without intent to die?      Never      Previous self-harm

If so, please provide the following information: the approximate date you last self-harmed, the method(s) used, your age at first self-harm, how often/how many times you have self-harmed, what feelings/situation cause you to engage in self -harm:

Have you ever physically harmed anybody else?      Never      I have previously harmed another

If so, please provide further information: how many times has this happened? What had been the situation(s); what was/were the outcome(s)? Were there ever any physical instruments involved?

### Psychiatric Medication History

List ALL psychiatric medications you have ever been prescribed, including any antidepressants, benzodiazepines, sleep medications, stimulants, mood stabilizers, antipsychotics, or other medications used for psychiatric purposes. Include the maximum daily dosage, the duration of use, the specialty of the prescribing physician, the indication, the efficacy, and the reason for discontinuation, if known:

- Antidepressants: Medications like Fluoxetine (**Prozac**), Sertraline (**Zoloft**), Escitalopram (**Lexapro**), Citalopram (**Celexa**), Venlafaxine (**Effexor**), Duloxetine (**Cymbalta**), Paroxetine (**Paxil**), or Bupropion (**Wellbutrin**).
- Benzodiazepines: Medications like Alprazolam (**Xanax**), Lorazepam (**Ativan**), Diazepam (**Valium**), Clonazepam (**Klonopin**), Clorazepate (**Tranxene**), Triazolam (**Halcion**), or Temazepam (**Restoril**).
- Sleep Medicines: Medications like Zolpidem (**Ambien**), Eszopiclone (**Lunesta**), Zaleplon (**Sonata**), Suvorexant (**Belsomra**), Ramelteon (**Rozerem**), Mirtazapine (**Remeron**), Doxepin (**Silenor**), or Trazodone (**Desyrel**).
- Stimulants: Medications like Methylphenidate (**Ritalin**), Amphetamine/Dextroamphetamine (**Adderall**), Lisdexamfetamine (**Vyvanse**), Dexmethylphenidate (**Focalin**), Armodafinil (**Nuvigil**), or Modafinil (**Provigil**).
- Mood Stabilizers: Medications like Lithium (Lithobid/Eskalith), Divalproex Sodium (**Depakote**), Valproic Acid (Depakene), Lamotrigine (**Lamictal**), Carbamazepine (**Tegretol**), or Oxcarbazepine (**Trileptal**).
- Antipsychotics: Medications like Risperidone (**Risperdal**), Olanzapine (**Zyprexa**), Quetiapine (**Seroquel**), Aripiprazole (**Abilify**), Clozapine (**Clozaril**), Haloperidol (**Haldol**), or Chlorpromazine (**Thorazine**).
- Other Medications Used for Psychiatric Purposes: Medications like Gabapentin (Neurontin), Propranolol (Inderal), Clonidine (Catapres), Buspirone (**BuSpar**), atomoxetine (**Strattera**), or Prazosin (Minipress).

Medication Name: Dates Taken: For How Long: Max Dose: Prescriber: Reason Taken: Worked? Why Stopped:

**Family History** Please provide the following information in regards to your blood relatives (living or dead):

Paternal     Living/Deceased:   Age Now/Age at Death:   Health Now/Cause of Death:   Location (if Alive):

Grandfather:

Grandmother:

Maternal     Living/Deceased:   Age Now/Age at Death:   Health Now/Cause of Death:   Location (if Alive):

Grandfather:

Grandmother:

Living/Deceased:   Age Now/Age at Death:   Health Now/Cause of Death:   Location (if Alive):

Father:

Mother:

Older/Younger:   Brother/Sister:   Living?   Years Older/Younger:   Psych. Diagnoses:

Sibling:

Sibling:

Sibling:

Sibling:

Sibling:

Sibling:

List any other blood relatives (aunts/uncles/cousins) with psychiatric disorders, including their mental health diagnoses, psychiatric hospitalizations (if any), and if any blood relative died by suicide:

List any blood relatives (parents, grandparents, siblings) with a history of substance use, including the substance(s) they used, how long they used for, and if they ever regained sobriety:

Do any of your blood relatives have medical history of the following: (indicate "No" or "Yes" for each):

Diabetes:	No	Yes	High Blood Sugar:	No	Yes
High Cholesterol:	No	Yes	Heart Disease:	No	Yes
High Blood Pressure:	No	Yes	Stroke:	No	Yes
Seizures:	No	Yes			

List any blood relatives with medical problems such as heart disease, cancer, or diabetes, including their problems. This list may contain previously-mentioned family members (parents/grandparents/siblings):





**Substance History**

Do you use nicotine-containing products?      Never      I have used/do use nicotine products:

If yes, which products (i.e. cigarettes, vape, dip), how often, age started, if currently using:

If yes, have you tried to quit?      Never      I have tried to quit nicotine before:

If yes, provide more information about your attempts at quitting (methods attempted, etc.):

Are you interested in discussing nicotine cessation, including medication treatment options?

I AM interested in nicotine cessation

I am NOT interested in nicotine cessation

At what age did you take your first drink/first use drugs?

Do you think you have any alcohol or drug problems?

Does your family think so?

Do you use alcohol or drugs regularly?      I do not use regularly      I use substance(s) regularly:

List all substances used in the last 12 months:

How long have you used these substances for:

Any current legal problems/charges pending due to alcohol or drug use?      No      Yes:

Describe, if yes:

Ever charged with a DWI/DUI?      I was NEVER charged with a DWI/DUI      I WAS charged:

Describe, if yes:

Describe current use pattern (companions, situations, places, amount, drink of choice, drinks per week):

Has your use of alcohol or drugs increased/decreased recently?      No changes      Yes (describe):

Regarding your use of alcohol or drugs, have you ever:

Drunk to the point of blackouts?

Missed work due to use of alcohol or drugs?

Been violent while using alcohol or drugs?

Felt you ought to cut down?

Become annoyed by others criticizing your use of alcohol or drugs?

Felt bad or guilty about your use of alcohol or drugs?

Had a drink/used drugs first thing in the morning to steady nerves or stop a hangover?

**Substance History (Continued)**

Have you ever been in an alcohol or drug rehab program?      Never in rehab      I've been to rehab:

If so, please provide the following information regarding each stay: MM/YYYY, location, length of stay, whether court-ordered or voluntary, substance treated for:

Have you ever gone to AA/NA meetings?      Never gone to AA/NA meetings      I've attended:

If so, when was your last meeting (approximate MM/YYYY):

**Legal History**

Any other past legal problems (not substance related)?      Never legal problems      Legal problem:

If so, describe:

Ever been incarcerated? (jail/prison)      I've never been incarcerated      I was incarcerated before:

If so, describe:

**Employment** Employment changes in the last 5 years:

<u>Employer:</u>	<u>Type of Work:</u>	<u>Year Changed:</u>	<u>Reason:</u>
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List all cities in which you have lived in the past 5 years:

Any other information you feel the doctor should know (including any information that did not fit above):

**By typing or signing your name below, you acknowledge and agree that:**

1. *The information provided in this form is complete and truthful to the best of your knowledge. You understand that the details you provide (or omit) may be used in medical decision-making.*
2. *Submission of this form alone does not establish a patient-physician relationship.*
3. *Your typed name below serves as a legally binding signature, equivalent to a handwritten signature.*

**Signed:**

**Dated:**

*Your submission will be reviewed during our operating hours. Most individuals receive a follow-up message within approximately 48 operating hours, using one of the communication methods you provided, or through another secure channel.*

*If, after review, we determine that we are not able to initiate care, your form and any associated information will be securely deleted in accordance with HIPAA requirements.*