PSYCHIATRIC AND MEDICAL HISTORY

If any item below does not apply, please enter N/A

Client Information

Patient Name:_______________________________________ DOB: ______________________

Marital Status: ☐ Married ☐ Single Preferred Pronouns: ______________________________

Employer:______________________________ or School: ______________________________

Language Preference:_____________________ Reading Level: __________________________

Last Grade Completed:____________________ Degree Earned: _________________________

Military Service? ☐ Yes ☐ No Branch: ___________ Type of Discharge:____________________

Social History

City of Residence:_______________________ Do you live with anyone? ☐ Yes ☐ No

With Whom?___________________________ Status of environment? ☐ Abuse ☐ Neglect

Support:

☐ Spouse ☐ Close Friend

☐ Partner ☐ Group of Friends

☐ Nuclear Family ☐ Church/Mosque/Temple/Support Group

☐ Extended Family ☐ Service System

☐ Other

Religious Affiliation? ☐ Yes ☐ No Importance of faith in your life (scale of 1-10):_____________

Prior/Current criminal record? ☐ Yes ☐ No Currently working with attorney? ☐ Yes ☐ No

If yes, please explain:____

Current Issues/Family History

Why are you seeking therapy or medication management at this time?_____________________

____

What is happening that makes this problematic? ____________________

What are your goals for therapy/treatment? ____________________

If you are currently in a relationship, which of the following problems, if any, do you have with your partner (please check those that apply)

- ☐ Conflict about money
- ☐ Conflict about friends
- ☐ Conflict about religious beliefs
- ☐ Conflict about sex
- ☐ Conflict about time together
- ☐ Other
- ☐ Conflict about employment
- ☐ Conflict about spouse's family
- ☐ Conflict about stepchildren
- ☐ Conflict about lifestyle
- ☐ Conflict about children
- ☐ Conflict about substance use

Family of Origin/Children

Parents/Siblings/Guardians	Age	Level of Contact 1-5 (1=distant, 5=close)	Living (L) Deceased (D)

Children	Age	Level of Contact 1-5 (1=distant, 5=close)	Living (L) Deceased (D)

Medical History

Have you experienced any of the following? (please check those that apply):

□ Alcoholism	□ Chronic Pain	□ Headaches	□ Smoking
□ Allergies	□ Degenerative Disease	□ Head Injury(ies)	□ Thyroid Issues
□ Arthritis	□ Diabetes	□ Hearing Problems	□ Tremors
□ Asthma	□ Drug Addiction	□ Hormonal Issues	□ Vision Problems
□ Cancer	□ Epilepsy	□ Hypertension	□ Other
□ Chest Pain	□ Fainting	□ Obesity	

If other please list: ____

Pain level for above conditions (1-10)? ___________ Type of pain? ________________
(throbbing, aching, etc.)

Any Hospitalizations (Medical or Psychiatric) in the past 3 years? □ Yes □ No Reason: _____

____

____

____

Are you pregnant? □ Yes □ No Need for prenatal care? □ Yes □ No

Medications

Medication/Dosage	Purpose	Prescribing Doctor

Previous Psychiatric Medication/Dosage	Purpose	Prescribing Doctor

Please list drug allergies: ____

Do you smoke Nicotine? □ Yes □ No How much? ______________________________

Psychiatric History

Past Counselor/Psychiatrists	Dates of Treatment

Family Member Psychiatric History	Diagnosis

Substance Use/Abuse History

Substance	Quantity	Frequency	Period of Time	Date of last use

Any Previous Suicide Attempts? □ Yes □ No

Nutritional History

Do you eat 2 meals or less per day? □ Yes □ No How many?________________________________

Do you follow a special diet due to illness? □ Yes □ No Please Specify:______________________

____

History of binging/purging/restricting/etc? □ Yes □ No Please Specify:______________________

____

Do you eat fast food more than 2x/week? □ Yes □ No How often? _________________________

Other

Is there anything else you would like your clinician/provider to know about you? _____________

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8224 Mentor Ave #208, Mentor, OH 44060 • 110 Traders Cross, Bluffton SC 29909 • 2375 East Camelback Rd #600, Phoenix, AZ 85016
Toll Free: 888 996 9374 • Office: 440 392 2222 • Fax: 440 565 2349

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