Family Psychiatric Associates
Patient History Form

IDENTIFYING INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

FORM COMPLETED BY: PATIENT ☐ PARENT ☐ OTHER ☐

DATE FORM COMPLETED: _____

REASONS FOR SEEKING TREATMENT: _____

_____

_____

_____

DURATION OF PROBLEM: 1-3 mos.☐ 6-12 mos.☐ 1-2 yrs.☐ 3-5 yrs.☐ 5-10 yrs.☐ >10 yrs. ☐

PRIOR TREATMENT: YES ☐ NO☐

IF YES, PLEASE DESCRIBE THE THERAPY, MEDICATION, OR BOTH: _____

_____

_____

_____

PREVIOUS MEDICATION USED AND THE OUTCOME: _____

_____

_____

_____

PREVIOUS PSYCHIATRIC HOSPITALIZATIONS (ALONG WITH WHERE, WHEN, WHY, AND FOR HOW LONG): _____

_____

_____

_____

FAMILY DATA

WHO LIVES IN YOUR HOME?

NAME	AGE	RELATIONSHIP

EDUCATION

YOUR OCCUPATION: _____

HOW LONG HAVE YOU BEEN AT YOUR CURRENT JOB: _____

ARE YOU A HIGH SCHOOL GRADUATE? Yes ☐ No ☐ GED ☐

ARE YOU A COLLEGE GRADUATE? Yes ☐ No ☐

FIELD OF STUDY: _____

SUBSTANCE USE/ABUSE

DO YOU USE ALCOHOL? Yes ☐ No ☐

IF YES, PLEASE NOTE FREQUENCY AND AMOUNT: (e.g. 3 times/week 4-6 beers) _____

DO YOU USE TOBACCO OR SMOKE CIGARETTES? Yes ☐ No ☐

IF YES, PLEASE NOTE FREQUENCY AND AMOUNT: (e.g. 1 pack/day)

_____

DO YOU USE DRUGS SUCH AS MARIJUANA OR OTHER DRUGS? Yes ☐ No ☐

IF YES, PLEASE NOTE THE DRUG AND THE FREQUENCY OF USE: _____

_____

_____

_____

LEGAL HISTORY

ANY HISTORY OF LEGAL PROBLEMS (e.g. arrests/incarceration)? Yes ☐ No ☐

IF YES, PLEASE PROVIDE A BRIEF EXPLANATION: _____

_____

_____

_____

FAMILY PSYCHIATRIC AND SUBSTANCE ABUSE HISTORY

IS THERE ANY HISTORY OF PSYCHIATRIC PROBLEMS IN YOUR FAMILY (e.g. depression, anxiety, bipolar disorder, schizophrenia, ADHD, suicide, substance abuse, violence, etc.)? Yes ☐ No ☐

IF YES, PLEASE DESCRIBE: _____

_____

_____

_____

HAS THERE BEEN ANY TRAUMATIC EVENTS IN YOUR LIFE? Yes ☐ No ☐

IF YES, PLEASE DESCRIBE: _____

_____

_____

_____

MEDICAL/HEALTH HISTORY

NAME OF PRIMARY CARE PHYSICIAN: _____

ADDRESS/PHONE: _____

DATE OF LAST PHYSICAL: _____

DO YOU HAVE ANY CHRONIC HEALTH CONDITIONS, SUCH AS ASTHMA, HIGH BLOOD PRESSURE, HEART PROBLEMS, ETC? Yes ☐ No ☐

IF YES, PLEASE LIST: _____

LIST ANY CURRENT MEDICATIONS AND DOSAGES, IF KNOWN: _____

_____

_____

DO YOU HAVE ANY ALLEGIES TO MEDICATIONS? Yes ☐ No ☐

IF YES, PLEASE LIST: _____

_____

_____

IS THERE ANY OTHER INFORMATION THAT YOU WOULD WISH TO PROVIDE?

_____

_____

_____

_____

_____