Patient Information

Name:_____ **Date:**_____

Reason For This Visit:_____
_____
_____
_____.

Referring Physician:_____

Primary Family Physician:_____

Current Medications (Include Dosages, Herbals and Supplements**):**_____
_____
_____
_____.

Allergies:_____.

Current Health: □ **Poor** □ **Fair** □**Good** □**Excellent**

Current/Past Illnesses:_____
_____
_____
_____.

Are You Pregnant? Yes No N/A Trying to Get Pregnant? Yes No N/A

Please List Any Psychiatric Medications You Have Tried Before:_____
_____
_____.

Have You Ever Been Hospitalized For Psychiatric Reasons? Yes No
If Yes, Where and When:_____
_____
_____.

Have Any Family Members Experienced Mental Health or Substance Abuse Problems?
If Yes, Please List Relationship and Problem:_____
_____
_____
_____.