PATIENT SELF REPORT

Name of PCP: _____ **Address:** _____ **Phone:** _____

Current medications: Please list the names of prescribed and non-prescribed drugs and over the counter herbs/replacements you are using.

Medication (Name, Dose, Frequency)	Clinician Comments

Previous Psychiatric Medications: Please list the names of prescribed and non-prescribed psychiatric drugs you have used in the past.

Name of Medication	Clinician Comments

Do you have any medication allergies? Please list:

_____

Previous MEDICAL History	*Clinician Evaluation (for official use only)*
Illnesses: _____ _____ _____ Surgeries: _____ _____ _____ Describe your obstetrical history: _____ _____ _____ Describe your method of contraception: _____ Have you gained or lost weight in the last 6 months? ☐ Yes ☐ No If yes, explain: _____	

Patient Label

Previous PSYCHIATRIC History:	*Clinician Evaluation (for official use only)*
Have you ever been hospitalized? ☐ **Yes** ☐ **No** When? _____ Where? _____ Diagnosis? _____ Benefits? _____ Have you ever seen a Psychiatrist? ☐ Yes ☐ No For what condition? _____ Have you ever seen a Counselor/Therapist? ☐ Yes ☐ No For what condition? _____ Have you ever made suicide attempt? ☐ Yes ☐ No If yes, details: _____ Violence (any self-injury, injury to others)? ☐ Yes ☐ No If yes, explain: _____ Alcohol (quantity per day, is it or has it been a problem)? ☐ Yes ☐ No Drugs (present/past use, is it or has it been a problem)? ☐ Yes ☐ No Caffeine? ☐ Yes ☐ No If yes, describe: _____ Nicotine use? ☐ Yes ☐ No If yes, describe (amount/frequency): _____	
Family/Social History:	*Clinician Evaluation (for official use only)*
Any mental illness in your family (including addictions)? ☐ **Yes** ☐ **No** If yes, describe: _____ Family of Origin (where were you born and raised)? _____ How many siblings? _____ What was childhood like? _____ Marital History? _____	

Patient Label

Family/Social History (cont):	*Clinician Evaluation (for official use only)*
Abuse: Sexual abuse? ☐ Yes ☐ No If yes, explain: _____ Physical abuse? ☐ Yes ☐ No If yes, explain: _____ Emotional abuse? ☐ Yes ☐ No If yes, explain: _____ **Current Social/Family System:** Child(ren)? ☐ Yes ☐ No Who are the supports in your life? _____ Who lives with you? _____ Are you working outside the house? ☐ Yes ☐ No If yes, where and doing what? _____ Education? _____ Any legal problems? ☐ Yes ☐ No If yes, explain: _____ Any financial problems? ☐ Yes ☐ No If yes, explain: _____ Any military service? ☐ Yes ☐ No Do you feel safe? (home, work, school)? _____ Sexual Orientation? _____ Religious beliefs/values? _____ What do you do in your spare time? _____ Last physical examination? _____ What are your goals for treatment? _____	

Patient Label