

Presenting Complaints of Patient:

Nature: What problem(s) led you to seek help at this time?

Apparent Cause of Crisis: What situations, events or stressors led to this problem?

Symptoms:

History of Presenting Complaints:

Have you had therapy before? If so what type of therapy & for what problems?

Did you benefit from past therapy? Yes No

Who is your regular health care provider? (Doctor, Nurse, Healer, other)

Provider's Name: _____ Phone #: _____

Patient's Personal History: _____

Single Married Divorced Common-Law Separated
Widowed Student

If you have dependants:

Dependants Name: _____

Dependants Age: _____

Dependants Sex M F M F M F

Patient's siblings: _____ M/F _____ M/F _____ M/F

Ages: _____

Parents: Married Divorced Single Common-Law Widowed

Employment: Employed Unemployed Self-employed Student

Company Name: _____ Address: _____

Any known mental health issues in your family you are aware of?

Mom Grandmother Grandfather Sister Brother Uncle/Aunt

Dad Grandmother Grandfather Sister Brother Uncle/Aunt

History of Mental Illness: _____

Mental history

Have you been treated for a Psychiatric Illness in the past year? Yes No

If Yes, Diagnosis: _____

Was Medication prescribed? No Yes **If yes,**

Current list of medications:

Medication Name	Dose	Frequency	Time of last dose	Side Effects

Vitamins: _____

Herbal Remedies: _____

Known allergies to medications: _____

If other treatment: What, Where, When, with Who?

Past adherence to prescribed treatment: Good Fair Poor

Assess Sleep & Rest for Current or Past Problem

Do you have problems with your sleep habits? Yes No

Normal bedtime _____ Normal awake time _____ Total Hours _____

Do you feel rested after a night's sleep? Yes No

What helps you sleep?

HOW DID YOU HEAR ABOUT US?

Dr's Referral Friend Website E.A.P. Other