Patient Name _____

Psychiatric History (should include all prior inpatient and outpatient treatment, include responses to medications):

_____

_____

_____

Medical History (should include previous illness, medications with dose, current physical problems, and family history. For children, include pre- and perinatal events, etc.):

_____

_____

_____

_____

Allergies/Adverse Reactions/Side Effects:

_____

_____

SUBSTANCE ABUSE

Has the patient ever abused drugs or alcohol? YES NO
If yes, describe (include substance, amount frequency, first and last use, previous treatment, etc.)

Substance	Amount	Frequency	First Use	Last Use

Previous treatment: Outpatient (Where?, When?)_____
Inpatient (Where?. When?)_____

Cigarette use? YES NO Amount _____ Caffeine use? YES NO Amount _____
Over the counter drugs _____

PATIENT HEALTH

Birth Weight, If known _____
Any problems with pregnancy or delivery? YES NO
Describe:_____

_____

Developmental Milestones
Infancy: Birth to two years. List any significant delays/problems such as feeding problems or slow to walk or talk:

_____

_____

Toddler/Preschool: 2 – 5 years. List any developmental delays/difficulties such as trouble with toilet training, speech, or self-care:

_____

_____

School Age: 8 – 12 years of age. Describe any delays/problems such as attention problems, school refusal or early puberty:

_____

_____

Middle/High School: 13 – 18 years of age. Describe any delays/problems:

_____

_____