Patient Self Report History

This form is to save you and your practitioner's time in the interest of providing you with the best service possible. All information on this form is considered confidential. Please answer as carefully and completely as possible.

Name: _____

Date: _____ Birth Date: _____

Gender: _____Preferred pronouns:_____

Best phone number to reach you: _____

Email address: _____

Home address: _____City: _____ Zip: _____

Referred By: _____Phone #: _____

Primary Care MD Name: _____Phone #:_____

Emergency Contact

Name:_____Relationship:_____

Phone #:_____

About your current problems
Please describe the problems that have brought you here to receive care.

ANY PRIOR PSYCHIATRIC, OR CHEMICAL DEPENDENCY SERVICES

Name of treatment setting; i.e. outpatient/inpatient	Date of Service

SUBSTANCE ABUSE HISTORY (Please circle either YES/NO):

Have you ever felt you should cut down on your drinking/drug use? **Yes/No**
Have people annoyed you by criticizing your drinking/drug use? **Yes/No**
Have you ever felt bad or guilty about your drinking/drug use? **Yes/No**
Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? **Yes/No**

Do you have any family history of psychiatric or chemical dependency problems? If so please describe below.

List all known drug allergies:_____

PHYSICAL HEALTH SCREENING

Have you had a problem/diagnosis/treatment procedure regarding any of the following?

Please check (**X**) to all that apply.

CURRENT Problem	PAST Problem	
		Shortness of Breath
		Coughing up blood
		Bleeding from any part of the body
		Chest pain/ palpitation
		MRSA Infection
		Stroke
		Sudden loss of Smell, Taste, Vision, Hearing, Sensation
		Convulsions/ Seizures
		Motor coordination/ paralysis
		Sexually transmitted disease
		Frequent severe headaches
		Frequent lingering cough
		Swelling of the hands & feet
		Night sweats/ fevers
		Dizziness/ fainting spells
		Pain in back or extremities
		Jaundice/ hepatitis
		Increased thirst/ urination
		Abdominal pain
		Eating disorder
		Unintentional weight loss/gain
		Joint/ back problems
		Asthma
		Thyroid/ gland problems
		High blood pressure
		Diabetes
		Kidney disease/ stones
		Cancer (within last 5 years)
		Arthritis
		Tuberculosis/ exposure
		Heart disease
		Anemia
		Ulcers
		Skin problems
		Nutrition problems
		Smoking
		Drugs
		Alcohol
		Hormone replacement therapy
		Other:
		Surgeries/ injuries:

List Current / Recent Medications and their dose and frequency:

_____
_____
_____
_____
_____

Current herbal/alternative treatments*:*

_____
_____
_____

RELATIONSHIP HISTORY

How do you describe your sexual orientation? _____

Are you sexually active? Yes_____ No_____

What method do you use to help prevent STD's/HIV? _____

Marital status: Single ____ Married _____ Divorced _____ Widowed _____ Partnered _____

Children/ stepchildren:

Where do children live?

LIVING ARRANGEMENTS/ HOME ENVIRONMENT

With whom do you currently live? _____

Are there any concerns about living arrangements? _____

EDUCATIONAL HISTORY

Highest level of education completed _____

OCCUPATIONAL HISTORY

Occupation: _____ Current position held: _____

If not currently working, date you last worked: _____

List name of employer:_____

ETHNIC/ CULTURAL AFFILIATION

Describe any cultural or ethnic practices or beliefs that will affect or influence your treatment.
Were you reared outside the US? Yes_____ No_____ If yes, where?_____

Primary language, if other than English? _____

SPECIAL ACCOMMODATION NEEDS

Do you have any accommodation needs related to disability?
If so please specify.

For Women Only:

Are you pregnant? ***Yes/No***
Are you currently using birth control? ***Yes/No***
Any feeling of depression occur after childbirth? ***Yes/No***
*What birth control method are you currently using if any?*_____