Patient History Form

Name:		**MR#:**	
DOB:		**Encounter Date:**	
Age:		**Sex:**	

Chief Complaint

☐ Abuse	☐ Anger	☐ Confusion	☐ Generalized Anxiety Disorder	☐ Obsessive Compulsive Disorder
☐ Acute Grief Reaction	☐ Anxiety	☐ Delusion	☐ Hallucinations	☐ Panic Attacks
☐ ADHD	☐ Behavior Problems	☐ Dementia	☐ Hyperactivity	☐ Schizophrenia
☐ Agitation	☐ Bipolar Disorder	☐ Depression	☐ Insomnia	☐ Separation Anxiety Symptoms
☐ Alcoholism	☐ Combative Behavior	☐ Eating Disorder	☐ Mood Disorder	☐ Suicidal Thoughts

If other complaint, please describe:	

Allergies/Sensitivities

☐ **No Significant Allergies**

Allergy		Reaction	Allergy		Reaction
1.			2.		
3.			4.		
5.			6.		
7.			8.		
9.			10.		

Current Medications

☐ **No Known Current Medication**

Medication Name		Medication Name	
1.		2.	
3.		4.	
5.		6.	
7.		8.	
9.		10.	

Please enter additional Current Medication details if any:

Past Medical History

☐ No Significant Past Medical History

Medical History		When	Comments
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please enter additional Past Medical History details if any:

Surgical History

☐ No Significant Surgical History

Surgery		When	Doctor	Hospital
1.				
2.				
3.				
4.				
5.				

Please enter additional Surgical History details if any:

Family History

☐ No Significant Family History

Family History		Relation	Comments
1.			
2.			
3.			
4.			
5.			
6.			

Please enter additional Family History details if any:

Social History

Marital Status	
Children	
Exercise	
Pets	
Sexual history	
Alcohol	
Smoking Status	
Caffeine	
Current use of recreational or street drugs:	
Employment	

Please enter additional Social History details if any: