Hampton Mental Health Associates
Adult Psychiatric & Medical History

Answer these questions as completely as possible prior to attending your first appointment. Your responses will help us learn about your circumstances and assist you with individualized treatment for your problems.

Patient Name	DOB	Age	Gender

Street address _____ City or Town _____

Telephone number: Work _____ Home _____

Do you have a preference where we contact you: _____

Ethnicity: ☐White ☐African American ☐Native American ☐Hispanic ☐Asian ☐Middle Eastern ☐Other

Relationship status: ☐Married ☐Domestic partner ☐Single ☐Divorced ☐Separate ☐Widowed ☐Other

Employment status: ☐Employed full-time ☐Employed part-time ☐Unemployed ☐Disabled

☐Retired ☐Homemaker ☐Other

Do you have any special/disability needs we need to be aware of? _____

Height: _____ Weight: _____ Last Recorded Blood Pressure: _____

Date of Last Physical _____ Name of Primary Care Physician _____

List any allergies/reactions (plants, animals, medications) _____

_____

Who referred you to us

Is it OK to send information to referral source or primary physician: ☐Yes ☐ No

Presenting Problem/History of Present Problem:

What problems do you need assistance with? ☐Depression ☐Anxiety ☐Relationship problem

☐Anger or irritability ☐Adjustment to major life change ☐Alcohol/Drug abuse ☐Hallucinations

☐Suicidal Thoughts ☐Homicidal Thoughts ☐Coping with an illness or disability ☐Other (describe) _____

_____

Briefly describe the history of your problem and what you have tried to do about it so far: _____

_____

_____

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Psychiatric and/or Alcohol and Drug Abuse History:

Do you currently have a psychiatrist, psychologist, social worker or counselor?	☐Yes	☐No
If yes, name(s)		

List and describe all past treatment for psychological/psychiatric concerns or alcohol/drug problems:

Year	Doctor/Therapist	Inpatient/ Outpatient	Type of Treatment Name & Location of Treatment Facility (Include medication, psychotherapy, counseling, alcohol or drug counseling, psychological testing, ECT, etc.)

Past Medical History

Describe surgeries, major illnesses, accidents or hospitalizations for medical problems: ☐ None

Year	Where Treated	Type of Illness/Operation	Doctor/Therapist

Describe any current medical problems:

Current Medication and Dose	Prescription	How Often	Non-Prescription	What For

Patient Name	DOB	Age	Gender

Substance Use:

	Tobacco	Caffeine	Alcohol	Street Drugs
Date last used				
Type				
Amount per day				
Tried to Quit	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No

Family Psychiatric History:

Describe any family history of psychological difficulties, psychiatric illness, alcohol or drug abuse, history of violence or suicidal behavior:

☐Psychiatric ☐Alcohol/Drug ☐Suicidal ☐Violent behavior

Social History:

	Type of Work	Age or Date of Death	Physical Illness
Father			
Mother			
Brother/ Sister			
Spouse/ Partner			
Children/ Stepchildren			

Patient Name	DOB	Age	Gender

Any previous primary relationships and/or marriages? ☐Yes ☐No If yes, explain _____

_____

_____

What was your birth order and number of children in family (for example: oldest of 3, etc.)? _____

_____

Graduated from high school: ☐Yes ☐No If yes, what year

Education after high school: ☐Yes ☐No If yes, describe

Describe any school problems _____

Where are you employed? _____

How long have you been there? _____ Job title _____

Describe any job problems/concerns _____

Any legal or arrest history? ☐Yes ☐No Probation/Parole: ☐Yes ☐No

If yes, what type: ☐Traffic offenses ☐Alcohol/Drug ☐Property/Financial ☐ Assault/Violence/Weapons

Any armed services history? ☐Yes ☐No If yes, how long _____ Years

Discharge: ☐Honorable ☐Other Branch of service _____

Active religious practice: ☐Yes ☐No If yes, what religion

Who lives with you now in your household? _____

Hobbies and leisure activities _____

_____

_____

Any other comments or concerns you want to share? _____

_____

_____

_____

Patient signature or Patient's legal representative **(Relationship)** **(Date)**