

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
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Street address _____ City or Town _____

Email Address: _____

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?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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

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Substance Use:

	Tobacco	Caffeine	Alcohol	Street Drugs
Date last used				
Type				
Amount per day				
Tried to Quit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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			

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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)**