MEDICAL & PSYCHIATRIC HISTORY

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Please attach a copy of your government-issued ID Card.

Name:		**DOB:**
Address:		**SS#:**
City:	**State:**	**Zip:**

Home Phone:			
Mobile Phone:			
Email address:			
Preferred Contact (Circle One):	**Home**	**Mobile**	**Email**

Emergency Contact:
Phone(s):
Email:

Primary Care Physician:
Address:
Phone:

Current or Past Medical Conditions (Circle All that Apply):

Asthma/Respiratory Problems	Cardiovascular Problems	Intestinal Problems
High Blood Pressure	Epilepsy orSeizures	Thyroid Problems
Head Trauma	HIV/AIDS	Pain
Liver or Pancreas Problems	Diabetes	Weakness
STDs	Cancer	Dizziness
Other:		

Current or Past Mental Health Conditions (Circle All that Apply):

Depression Anxiety Bipolar Mood Disorder Psychosis Addiction

Outpatient Mental Health Treatment Including Current/Past Providers & Contact Info:

Inpatient/Residential Mental Health Treatment (Programs & Dates):

Have you ever attempted suicide? YES NO

Current List of Medicines/Doses:

Marital Status (Circle One): MARRIED SINGLE DOMESTIC PARTNER SEPARATED

Employment (Circle One): FULL TIME PART TIME UNEMPLOYED

Family History of Mental Illness or Addiction (Circle One): YES NO
Describe:

On Parole or Probation? (Circle One): YES NO

I have used the following substances:	Never	Now	Past	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine							
Marijuana							
Benzos / Other Sleep Aid							
Opioid Pain Medicines							
Legal Stimulants (pills)							
Cocaine & Crack							
Hallucinogens							
Inhalants							
Amphetamines & Meth							
PCP							
Methadone							
Heroin							
Ecstasy							
Other							

Outpatient Substance Abuse Treatment Including Programs & Contact Info:

Inpatient/Residential Substance Abuse including Programs and Contact Info:

Other Relevant Information:

I certify that the above information is accurate and complete.

_____

Hand written signature required. Today's Date

_____

Print Name Date of Birth