Patient History

Patient Name: _____ Date: _____

Occupation: _____ Educational Level: _____

Please review the following and check any *current* symptoms that pertain to you.

☐ Depressed Mood	☐ Inflated Self Esteem
☐ Sleep Problem	☐ Don't Seem to Need Sleep For Days
☐ Change in Appetite	☐ Racing Thoughts
☐ Decrease Interest	☐ Excessive Talking
☐ Decrease Energy	☐ Spending Spree
☐ Difficulty in Concentration	☐ Distractibility
☐ Guilt	☐ Impulsive Behavior
☐ Irritability	☐ Trying To Do Way Too Much
☐ Crying Spells	☐ See / Hear Things That May Not Be Real
☐ Excessive Worrying	☐ Suspect / Believe Things That May Not Be Real
☐ Often Tense / Keyed Up	☐ Can Not Stop Repetitive Thoughts
☐ Panic Attack	☐ Can Not Stop Repetitive Behavior
☐ Intrusive / Recurrent Memory of Past Time	☐ Hyper Vigilant

Past Psychiatric Treatment

Have you seen a psychiatrist in the past? ☐ No ☐ Yes

If yes, when and Psychiatrist's name: _____

Have you seen a therapist in the past? ☐ No ☐ Yes

If yes, when and Therapist's name: _____

Have you ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes

If yes, when and where were you hospitalized? _____

Have you taken any psychiatric medications in the past? ☐ No ☐ Yes

If yes, what are the names of the medications? What were the benefits of taking it? Did you experience any side effects? _____

_____

_____

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