



## Medical & Psychiatric History Form

Name: \_\_\_\_\_ Age \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Profession \_\_\_\_\_

Are you married? \_\_\_\_\_ been divorced? \_\_\_\_\_ How long ago did the divorce occur? \_\_\_\_\_

If yes, how many previous marriages have you had? \_\_\_\_\_ Have long have you been in your current relationship? \_\_\_\_\_ Church Affiliation? \_\_\_\_\_

Child's Name, Age, Sex, Adopted, Step, Biological, and who is living at home? (If you have children)

1. \_\_\_\_\_ F M \_\_\_\_\_

2. \_\_\_\_\_ F M \_\_\_\_\_

3. \_\_\_\_\_ F M \_\_\_\_\_

4. \_\_\_\_\_ F M \_\_\_\_\_

Are you currently or have you ever been in therapy? \_\_\_\_\_

If yes, when? \_\_\_\_\_

If so, Individual, Couples, or Family Therapy? \_\_\_\_\_

What were the presenting issues?

\_\_\_\_\_

Do you or did you have a Psychiatric Diagnosis?

\_\_\_\_\_

How long were you in therapy & was it helpful?

\_\_\_\_\_

Have you ever been suicidal or attempted suicide? \_\_\_\_\_ When? \_\_\_\_\_ Homicidal? \_\_\_\_\_

When? \_\_\_\_\_ Drug Overdose? \_\_\_\_\_ When? \_\_\_\_\_ Police called on you or arrested? \_\_\_\_\_ In jail? \_\_\_\_\_ When? \_\_\_\_\_ For what? \_\_\_\_\_

Are you currently having suicidal ideation or are suicidal or homicidal ideation?

\_\_\_\_\_

Have you ever been in a psychiatric unit or hospital? \_\_\_\_\_ When? \_\_\_\_\_

\_\_\_\_\_ What for? \_\_\_\_\_

What was your clinical diagnosis at the time and currently? \_\_\_\_\_

Any sexual abuse in your history? \_\_\_\_\_ Age \_\_\_\_\_ Any treatment? \_\_\_\_\_

Any physical abuse in your history? \_\_\_\_\_ Age \_\_\_\_\_ Any treatment? \_\_\_\_\_

Are you currently on medications? \_\_\_\_\_ If so, what kind & amount?

Who should we contact in case of an emergency?

Relationship \_\_\_\_\_ Phone number \_\_\_\_\_ Location \_\_\_\_\_

What is your psychiatrist name? \_\_\_\_\_ Phone \_\_\_\_\_

What is your current therapist name? \_\_\_\_\_ Phone \_\_\_\_\_

Please **circle** any of the following issues that may apply to you. And **check** those issues that apply to your family:

Alcohol use	Depression	Drug use	Infidelity
Anger problems	Loneliness	Chronic illness	Marital problems
Recent death of family/friend	Loss of faith in God	Loss of trust	Guilt
Loss of hope	Insecurity	Nervousness	Physical pain
Poor appetite	Pregnancy/Abortion	Premarital counseling	School problems
Recent loss of relationship	Eating problems	Loss of self-respect	Fear
Sleep problems	Behavior problems	Spiritual problems	Self-doubt
Violence problems	Relationship problems	Work related problems	Anxiety
Suicidal feelings	Recent major life changes	Sexual concerns	Abuse
Bipolar	Mood Swings	Compulsive Behaviors	Jealousy
Abandonment	Addictions	Pornography	Affairs
Personality Disorders	Unmotivated	Obsessive Thinking	Low Self Worth
Dependency	Isolation	Excessive Computer	Bulimia
Anorexia	Control/Power issues	Victimization	Parenting Issues
Financial Issues	Mania/Manic	Delusional thinking	Hallucinations
Physical Abuse	Trauma	Sexual Abuse	Verbal Abuse

Please expand on circled areas from above.

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Any other information you would like us to know about?

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Signature

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Date

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Signature

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Date