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MEDICAL INFORMATION FORM

Patient's Name: _____ Age: _____ Date of Birth: _____ / _____ / _____

Reason for Referral (Why are you here today):

_____

Secondary Reason (other symptoms/problems of concern):

_____

Past Psychiatric History (diagnoses, hospitalizations, outpatient psychiatrists/therapists):

_____

Past Medical History (non-psychiatric medical conditions, operations/procedures, etc.):

_____

Current Psychiatric Medications (including dosages):

_____

Other medications (non-psychotropic):

_____

Past Psychiatric Medications:

_____

Medication Allergies:

_____

Family Psychiatric History:

_____

_____

Social History (occupation, marital status, who lives with you, other):

_____

Substance Use (cigarettes, alcohol, drugs):

_____

Past Trauma History (physical or sexual abuse, life threatening event, other):

_____

Current Significant Stressors (family/relational, work, financial, legal, medical, other):

_____

I hereby attest that the medical information provided above is actual and correct to the best of my knowledge

Signature of Patient: _____ Date: _____