**Medical History:** *Have you ever had any of these medical conditions?*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Seizure/epilepsy |  | Vitamin D deficiency |  | Low Thyroid function |
|  | Head trauma |  | Vitamin B-12 deficiency |  | High Thyroid function |
|  | Loss of consciousness |  | Heart disease |  | Kidney disease |
|  | Acid Reflux |  | Heart attack |  | Pituitary tumor |
|  | Irritable Bowel Syndrome |  | Diabetes Mellitus |  | Chronic pain |
|  | HIV disease |  | Pre-diabetes |  | Cancer: |
|  | Hepatitis B |  | High Blood Pressure |  |  |
|  | Hepatitis C |  | Stroke |  | Other: |

**Current Medications**: *Please include over the counter, vitamins, and supplements*

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Strength | Frequency | Reason |
|  |  |  |  |
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| --- | --- |
| Medication You are Allergic To: | Reaction |
|  |  |
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|  |  |  |
| --- | --- | --- |
| Surgery | Date | Reason |
|  |  |  |
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**Paychiatric history**

|  |  |
| --- | --- |
| Past psych. Provider(s) |  |
|  |  |
| Past psych. hospitalization |  |
|  |  |
| Past suicide attempts |  |
|  |  |
| Past self harm/mutilation |  |
|  |  |
| Other Information: |  |
|  |  |
| Past Medication trials |  |
|  |  |
|  |  |
|  |  |

**Family History**-*Please list all immediate family members/children, as well as any known extended family psychiatric history, including psych. Hospitalizations, suicide or ECT (shock treatments)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Living? | Medical Conditions | Psychiatric Conditions |
| Mother: |  |  |  |
| Father: |  |  |  |
| Bro/Sis |  |  |  |
| Bro/Sis |  |  |  |
| Bro/Sis |  |  |  |
| Bro/Sis |  |  |  |
| Bro/Sis |  |  |  |
| Son/Daughter |  |  |  |
| Son/Daughter |  |  |  |
| Son/Daughter |  |  |  |
| Son/Daughter |  |  |  |
| Son/Daughter |  |  |  |
| Other Family: |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Social History**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Substance Use | Past | Now |  | Past | Now |  | Past | Now |
| Cigarettes |  |  | CBD/CBN |  |  | Heroin/Pain Pills |  |  |
| Cigar |  |  | LSD |  |  | Huffing |  |  |
| Dip |  |  | Mushrooms |  |  | Others: |  |  |
| Chew |  |  | Ecstasy |  |  |  |  |  |
| Vaping-Nicotine |  |  | Cocaine/Crack |  |  |  |  |  |
| Vaping-Other |  |  | Methamphetamines |  |  |  |  |  |
| Marijuana |  |  | Stimulants |  |  |  |  |  |

**Employment**: FT /PT / Retired / Unemployed /Disabled/ Stay at Home

**Occupation**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birthplace**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Raised with: Mom / Dad / Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School**: Grade school / GED / High School / 2 year / 4 year /Graduate / Post-graduate / Trade

**Marital Status**: Single / Partnered / Married / Divorced / Separated / Widowed

**Spouse/Partner’s Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Together since:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of abuse**: emotional / physical / sexual / incest / domestic violence / none

Are you currently safe: Yes / No Who lives at home with you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Military Service**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal History**: None / DUI / Arrest / Jail / Prison:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pets at home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hobbies**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you exercise regularly?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any other information you think is important to share with your provider**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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