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Patient History Form

Today's Date _____
Patient Name _____ Date of Birth _____
Pronouns _____
Address _____ City _____ State _____ Zip _____
Phone (Cell phone) _____ (Home Phone) _____
Email Address _____
Emergency Contact _____ Phone _____
Who do you live with? _____
Marital Status _____
Sexual Orientation _____ Gender Identity _____

Do you have children? Yes No

If yes, please list names and ages:

Referring Doctor or other referral source _____
Current psychiatrist and/or therapist name _____
Contact information _____
Date last seen _____
Pharmacy name and full address (must include Zip Code) _____

Chief Complaint (reason for today's visit):

Clinical

State in your own words the nature of the issues you'd like to work on in treatment:

How old were you when your symptoms first began? _____

Give a brief history of the development of your clinical issue, from onset to present.
(Please attach a separate note addressing this if it is more convenient)

Whom have you previously received consultation and treatment from for mental health or addiction? (Please attach a separate note addressing this if it is more convenient)

Name	Form of treatment (therapy, medications)	Treatment dates and length of treatment	Medications prescribed, if any

Have you received any mental health diagnoses in the past? If yes, please list below:

Do you have a history of psychiatric hospitalizations? Yes No

If yes, please provide details below. (Please attach a separate note addressing this if it is more convenient):

Date	Reason for hospitalization

Have you ever made a suicide attempt? Yes No

Have you ever done self-harm behaviors? Yes No

If yes, please specify (i.e. Cutting, skin picking, hair pulling, other): _____

Have you ever had symptoms of an eating disorder? Yes No

If yes, please specify (Restrictive eating, binge eating, purging (self-induced vomiting):

Do you own a fire arm? Yes No

If yes, how many and what type? _____

In which situations do you use them? Hunting Self-defense Other _____

Please list below psychiatric medications you have taken in the past, including over the counter sleep aids. (Please attach a separate note addressing this if it is more convenient)

Dates taken	Medication name	Highest dose taken	Positive or negative result

Have you ever mis-used your medications, taken more or less than prescribed? Yes No

If yes, please describe pattern of mis-use? _____

Menstrual History (if applicable)

Do you currently have regular periods? Yes No

Date of last period: _____

Does your menstrual cycle affect your mood? _____

Do you take oral contraceptives? Yes No

If you are no longer menstruating, when was your last period? _____

Substance Use History

Do you have a history of addiction to alcohol or other drugs? Yes No

If yes, please explain including any prior treatments for addiction you have received.

(Please attach a separate note addressing this if it is more convenient)

Do you drink alcohol? Yes No

How many days a week do you drink? _____

How many drinks do you drink per day? _____ How many drinks do you drink per week? _____

What is the most drinks you have had in one day (in the last month)? _____

Do you smoke cigarettes or vape nicotine? Yes No

If so how many cigarettes do you smoke per day? _____

If you vape nicotine how many cartridges do you use in a week? _____

Are you currently using any recreational drugs either currently or in the past? Check all applicable:

Marijuana Active use? Yes

Cocaine Active use? Yes

Heroin Active use? Yes

Opiate pain medication Active use? Yes

Amphetamines Active use? Yes

Psilocybin or LSD Active use? Yes

MDMA/Ecstasy/Molly Active use? Yes

Other drugs (Please list) _____

Trauma History

Have you ever experienced or witnessed abuse or assault? Yes No

If yes, please specify (i.e. Physical, Sexual, Emotional): _____

Have you experienced or witnessed any other significant life trauma? Yes No

If yes, please specify: _____

Family History

Do you have any family history of mental health issues or addiction?

If so, please list family member and issue:

Mother _____

Father _____

Siblings _____

Maternal Grandparents _____

Paternal Grandparents _____

Medical History

List all illnesses or health problems you have now or have had in the past. Include surgeries.

(Please attach a separate note addressing this if it is more convenient)

Do you have any drug allergies? Yes No

If yes, please specify _____

Name and Contact information of Primary Care Physician

Sleep History

Do you have any difficulty sleeping?

Never Often Sometimes Getting to sleep Staying awake

What time do you go to sleep? _____ Wake up? _____

Does anyone complain that you snore? Yes No

Do you stop breathing at night? Yes No

Do you wake up tired in the morning? Yes No

Do you fall asleep in the daytime? Yes No

Caffeine intake per day: _____

Do you exercise? Yes No

If yes, specify type and frequency: _____

Have you ever had a sleep study? Yes No

If yes, please give me a copy of the results.

Review of Systems

Are you currently having, or have you had problems with: (check all that apply)

General well-being

- Fever
- Weight loss (>10#)
- Excess fatigue
- Recurrent Nausea / vomit
- Night sweats

Eyes

- Wear glasses
- Date of last exam _____
- Infections
- Injuries
- Glaucoma
- Cataracts
- Blurred vision
- Trouble focusing
- Recent change in vision

Ears, Nose, Mouth and

Throat

- Wear hearing aids
- Date of last exam _____
- Hearing loss
- Ear infection
- Pressure in ears
- Ringing in ears
- Pain in ears
- Balance disturbance
- Itching in ears
- Dizziness
- Nasal congestion
- Nasal drainage
- Nosebleeds
- Sinus problems
- Sinus infections
- Sinus headaches
- Throat infections
- Difficulty swallowing
- Lip or mouth sores
- Sore throats

Respiratory

- Chronic cough
- Emphysema
- Bronchitis
- Asthma
- Chronic obstruction
- Pulmonary disease
- Shortness of breath
- Oxygen use at home
- Pneumonia
- Lung cancer
- Tuberculosis
- Blood in saliva
- Date of last chest X-ray _____

Cardiovascular

- Chest pain
- Date of last EKG _____
- Heart attack
- High blood pressure
- Low blood pressure
- Irregular heartbeat
- Heart murmur
- Arm and leg swelling
- High cholesterol

Gastrointestinal

- Blood in vomit
- Indigestion
- Nausea / vomiting
- Jaundice
- Abdominal pain
- Change in bowel habits
- Ulcers or Gastritis
- Colon, liver, stomach cancer
- Hepatitis

Hematologic

- Anemia
- Hemophilia
- Easy bleeding / bruising
- Swollen glands

Genitourinary

- Urinary tract infection
- Painful urination
- Blood in urine
- Difficulty urinating
- Incontinence
- Kidney stones
- Prostate cancer
- Endometriosis
- Uterine, ovarian or cervical cancer

Neurological

- Disorientation
- Fainting / blacking out
- Light headedness
- Seizures
- Stroke
- Mini-stroke
- Memory problems
- Concentration problems
- Speech problems
- Facial weakness/ spasms
- Muscle weakness
- Coordination problems
- Uncontrolled shaking
- Headache
- Migraine

Endocrine

- Diabetes
- Hormone problems
- Low blood sugar
- Thyroid disease
- Increased appetite
- Excessive thirst
- Excessive urination
- Temperature intolerance
- Pituitary gland problems
- Bleeding tendencies

Immunologic

- Environmental allergies
- Hay fever
- Food allergies
- Immune system problems
- Connective tissue disease
- Frequent colds / infections

Skin

- Eczema or psoriasis
- Dermatitis
- Dry or scaling skin
- Rashes
- Changes in skin color
- Changes in moles
- Skin cancer
- Breast pain or swelling
- Date of last Mammogram _____

Musculoskeletal

- Broken bones
- list: _____
- Arm or leg weakness
- Joint pain or swelling
- Back pain
- Arthritis

Psychiatric

- Anxiety
- Depression
- Manic/Depression
- Schizophrenia
- Considering suicide / homicide
- Panic attacks
- Sudden mood swings
- Emotional difficulties
- Insomnia
- Other psychiatric problems
- Under psychiatric care
- Desiring psychiatric care

If you suspect you have Anxiety, Depression, ADHD, Mood Cycling Depression, Binge Eating, then please fill out the Diagnostic Survey forms located on my website.

PLEASE GIVE DR. GOLDFARB ANY LABWORK AND MEDICAL TESTS OR XRAYS YOU HAVE HAD IN THE PAST YEAR. YOU MAY REQUEST THAT YOUR DOCTOR FAX IT TO 212 570-1077

The above information is accurate to the best of my knowledge.

Patient Signature

Date

I have reviewed the above information with the patient.

Lisa Goldfarb, MD

Date