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PSYCHIATRY

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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)

_____
_____
_____
_____
_____

Current medications

_____
_____
_____
_____

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)

_____
_____
_____
_____

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	Hospital or Program	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 now 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? ☐	Past use? ☐
☐ Cocaine	Active use? ☐	Past use? ☐
☐ Heroin	Active use? ☐	Past use? ☐
☐ Opiate pain medication	Active use? ☐	Past use? ☐
☐ Amphetamines	Active use? ☐	Past use? ☐
☐ Psilocybin or LSD	Active use? ☐	Past use? ☐
☐ MDMA/Ecstasy/Molly	Active use? ☐	Past use? ☐

☐ 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*