

# TRUSTED THERAPY, INC

## PATIENT HISTORY FORM

Date: ____ / ____ / ____		
NAME: _____		Birthdate: ____ / ____ / ____
Last	First	M. I.
Age: _____ Sex: <input type="checkbox"/> F <input type="checkbox"/> M		
How did you hear about this clinic?		
Describe briefly your present symptoms:		
Please list the names of other practitioners you have seen for this problem:		
Psychiatric Hospitalizations (include where, when, & for what reason):		
Have you ever had ECT? _____ Have you had psychotherapy? _____		

<b>CURRENT MEDICATIONS</b>		
Drug allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes To what?		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

**PAST MEDICAL HISTORY**

Do you now or have you ever had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Crohn's disease         |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Colitis                 |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Pulmonary embolism  | <input type="checkbox"/> Anemia                  |
| <input type="checkbox"/> Hypothyroidism      | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Jaundice                |
| <input type="checkbox"/> Goiter              | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Hepatitis               |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia            | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever         |
| <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Kidney stones       |  |

Other medical conditions (please list):

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**PERSONAL HISTORY**

Were there problems with your birth? (specify)  
 Where were you born & raised?  
 What is your highest education?     High school     Some college     College graduate     Advanced degree  
 Marital status:  Never married     Married     Divorced     Separated     Widowed     Partnered/significant other  
 What is your current or past occupation?  
 Are you currently working? :  Yes     No    Hours/week \_\_\_\_\_    If not, are you  retired     disabled     sick leave?  
 Do you receive disability or SSI?  Yes     No    If yes, for what disability & how long? \_\_\_\_\_  
 Have you ever had legal problems? (specify)  
 Religion:

**FAMILY HISTORY**

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

**EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:**

Maternal Relatives:

Paternal Relatives:

## SYSTEMS REVIEW

In the past month, have you had any of the following problems?

### GENERAL

- Recent weight gain; how much \_\_\_\_\_
- Recent weight loss: how much \_\_\_\_\_
- Fatigue
- Weakness
- Fever
- Night sweats

### MUSCLE/JOINTS/BONES

- Numbness
- Joint pain
- Muscle weakness
- Joint swelling

Where?

### EARS

- Ringing in ears
- Loss of hearing

### EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

### THROAT

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

### HEART AND LUNGS

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

### NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

### STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

### SKIN

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

### BLOOD

- Anemia
- Clots

### KIDNEY/URINE/BLADDER

- Frequent or painful urination
- Blood in urine

### Women Only:

- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

### PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

### OTHER PROBLEMS:

### WOMENS REPRODUCTIVE HISTORY:

Age of first period:

# Pregnancies:

# Miscarriages:

# Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
<b>ALCOHOL</b>					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>CANNABIS:</b> Marijuana, hashish, hash oil					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>STIMULANTS:</b> Cocaine, crack					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>STIMULANTS:</b> Methamphetamine—speed, ice, crank					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>AMPHETAMINES/OTHER STIMULANTS:</b> Ritalin, Benzedrine, Dexedrine					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>BENZODIAZEPINES/TRANQUILIZERS:</b> Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>SEDATIVES/HYPNOTICS/BARBITURATES:</b> Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>HEROIN</b>					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>STREET OR ILLICIT METHADONE</b>					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>OTHER OPIOIDS:</b> Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>HALLUCINOGENS:</b> LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>INHALANTS:</b> Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>OTHER:</b> specify) _____ _____ _____					Yes <input type="checkbox"/> No <input type="checkbox"/>