Medical and Psychiatric History Form

Name: _____Date_____

Date of Birth_____Primary Care_____

Therapist/Counselor_____Therapist's Phone_____ ****ROI WILL STILL BE NEEDED FOR US TO CONTACT THEIR THERAPIST****

Preferred Pharmacy_____

What are the problem(s) for which you are seeking help?

1_____

2_____

3_____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist:

( )Depressive mood	( )Racing thoughts	( )Excessive Worry
( )Unable to enjoy activities	( )Impulsivity	( )Anxiety attacks
( )Sleep disturbance	( )Increase Risky Behavior	( )Suicidal thoughts
( )Loss of Interest	( ) Excessive energy	( ) Poor energy
( ) Change in Appetite	( )Increased Irritability	( )Hallucinations
( )Concentration/Forgetfulness	( )Crying spells	( )_____
( )_____	( )_____	( )_____

Medical History

Current medical problems:

Past Medical Problems, nonpsychiatric hospitalizations, or surgeries

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Allergies_____

Current Weight: _____Height_____

Have you ever had an EKG? ( )Yes ( )No If yes, when_____

Was the EKG ( ) Normal ( )Abnormal or ( )Unknown

List all prescription medications and how often you take them: (If none, write none)

Medication Name Total Dose Estimated Start Date

_____
_____
_____
_____
_____
_____
_____
_____
_____

Current over the counter medications or supplements:

_____
_____
_____
_____

Put a checkmark:

Personal/Family Medical History	You	Family	Which Family Member
Anemia			
Liver Disease			
Kidney Disease			
Heart Problems			
High Blood Pressure			
Asthma/Respiratory Problems			
Stomach or Intestinal Problems			
Cancer			
Fibromyalgia			
Seizure/Epilepsy			
Chronic Pain			
High Cholesterol			
Head Trauma/Concussion			
Diabetes			
Other:			

When your mother was pregnant with you, were there any complications during the pregnancy, birth, or developmental in the first few years of life:

_____

_____

_____

_____

Past Psychiatric History

	Dates	**Reason**	**Provider/Organization**
Outpatient Treatment			
Partial Hospitalization Program			
Rehabilitation/detox			
Inpatient			

Past Medication Trials: Put a checkmark on the medication you have tried in the past

Antidepressants	Antipsychotic
Prozac (Fluoxetine)	Seroquel (Quetiapine)
Zoloft (sertraline)	Zyprexa (Olanzapine)
Luvox (Fluvoxamine)	Geodon (Ziprasidone)
Paxil (Paroxetine)	Abilify (Aripiprazole)
Celexa (Citalopram)	Clozaril (Clozapine)
Lexapro (Escitalopram)	Haldol (Haloperidol)
Effexor (Venlafaxine)	Prolixin (Fluphenazine)
Cymbalta (Duloxetine)	Risperdal (Risperidone)
Wellbutrin (Bupropion)	Latuda (Lurasidone)
Remeron (Mirtazapine)	Vraylar (cariprazine)
Anafranil (Clomipramine)	Invega (Paliperidone)
Pamelor (Nortriptyline)	Other:
Elavil (Amitriptyline	
Viibrid	
Trintellix	
Trazodone	
Other:	

Anti-Anxiety	Mood Stabilizers
Xanax (Alprazolam)	Tegretol (carbamazepine)
Ativan (Lorazepam)	Lithium
Klonopin (Clonazepam)	Depakote (Valproate)
Valium (Diazepam)	Lamictal (Lamotrigine)
Buspar (Buspirone)	Topamax (Topiramate)
Other:	Neurontin (gabapentin)
	Trileptal (Oxcarbazepine)
	Other:

ADHD Medication	Sedative/Hypnotic
Adderall (amphetamine salt)	Ambien (Zolpidem)
Concerta (Methylphenidate)	Sonata (Zaleplon)
Ritalin (Methylphenidate)	Rozerem (Ramelteon)
Strattera (Atomoxetine)	Restoril (Temazepam)
Vyvanse	Lunesta (Eszopiclone)
Guanfacine (Intuniv)	Other:
Clonidine (Catapress)	
Other:	

Substance Use:

What	How often	How Much	Last Used
Alcohol			
Nicotine			
Marijuana			
Heroine			
Cocaine			
Other:			

Family Psychiatric History:

Has anyone in your family has been diagnosed or treated for:

Problem	Yes/no	Who	
Bipolar Disorder			
Schizophrenia			
Depression			
PTSD			
Alcohol use disorder			
Drugs			
ADHD			
Violence			
Other:			

I attest that all the information on this form is accurate to the best of my knowledge.

_____

Patient

_____

Signature of patient, parent, or guardian

Patient Name: _____ **Date**:_____

Insurance Information:

Primary Insurance:_____ ID:_____ Group#:_____

Policy Holder: _____ Date of Birth:_____ Employer:_____ Social:_____

Relationship to Policy Holder:_____

Secondary Insurance:_____ ID:_____ Group#:_____

Policy Holder: _____ Date of Birth:_____ Employer:_____ Social:_____

Relationship to Policy Holder:_____

AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION

Do we have permission to leave a message regarding appointments, etc on your voicemail? _____

I hereby give Paper Cranes permission to release information regarding my care other than myself to:

Name: _____ Relationship: _____

Name:_____ Relationship:_____

Patient Signature _____ Date: _____

AUTHORIZATION TO TREAT/RELEASE INFORMATION

I hereby give my permission to Paper Cranes Healthcare to administer treatment and to perform procedures that may be deemed necessary for the treatment of my health. I consent to the use of HIPAA-compliant transcription software for medical documentation and to the retrieval of my medication prescription history from pharmacies. I also hereby assign to the above-named practice all benefits provided by my insurance company policy or policies for medical care. **I understand that I am responsible for any balances due on my account.** I authorize the above-named practice to release all of my information in the processing of my claims.

Patient name:_____ Patient Signature: _____ Date:_____

Parent/Guardian:_____ Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIVING PATIENT RIGHTS AND HIPAA POLICY

I acknowledge that I have reviewed a copy of my patient rights and HIPAA policy, as deemed by Paper Cranes Healthcare.

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____