PATIENT INFORMATION SHEET

Please fill in all information to the best of your knowledge

_____	_____	_____
Patient Name	Date of Birth	Date

1) PSYCHIATRIC CONDITION or problems for which you are seeking evaluation:

2) PREVIOUS TREATMENT for the above conditions, including past psychiatric medications tried, therapists or psychiatrists seen, hospitalizations, dates:

3) MEDICAL PROBLEMS (such as heart disease, seizures, etc), including previous treatments or surgeries:

4) CURRENT MEDICATIONS, including prescribed and over-the-counter medications, as well as vitamins and herbal supplements:

5) ALLERGIES to Medications:

6) SUBSTANCE USE- tobacco, caffeine, alcohol, and drug, and any treatment:

7) Marital status, children, employment status, educational background, disabilities, and any other important information:

8) FAMILY HISTORY of psychiatric illness: