History Form

Patient Name: _____ **DOB:** _____ **Salutation**: Mr./ Mrs./ Ms./ Miss.

SEX: Male/Female **Handedness:** Right/Left **Highest Level of Education:** _____ **Race:** _____

Current/Past Occupation (s): _____

Social History: ___ Married ___Single ___Divorced ___Widowed ___Living w/Significant Other Name _____
Do you have a Power of Attorney __Yes __No (Must Provide) **Children**: ___Yes ___No **Names** _____

Sexual History: Are you sexually active: __Yes __No Sexual Partners past year:____ # men___ # women___ Any STD's _____

How Much Alcohol do you Consume Daily/Type _____ **Is there a History of Substance Abuse** _____

Presenting Problem(s) _____

Medications: Please list all medications or herbal supplements you take and their dosage:

Drug:	Dosage:	Drug:	Dosage:
		Allergies / Reactions:	

Names of current doctors:

Doctor	Phone Number:	Doctor:	Phone Number:

Past Psychiatric / Psychological Diagnoses andYear: _____

Have you ever Attempted Suicide, if yes explain: _____
List any Current/Past Medical Conditions and Year: _____

List any Neurological/History and Year: _____

Operations: List names and dates of all operations:

Year	Name of Operation	Type of Anesthesia	Complications

Have you or any blood relative had:	Yes	No	Who	Year
Substance use/abuse	____	____	_____	_____
Alzheimer's/Dementia	____	____	_____	_____
Depression/Anxiety	____	____	_____	_____
Epilepsy or seizures	____	____	_____	_____
Parkinson's	____	____	_____	_____
Stroke	____	____	_____	_____
Head Injury (Self)	____	____	_____	_____
Toxic Exposure (Self)	____	____	_____	_____
Other Conditions	____	____	_____	_____

List Test Done in the Past Year and Place Done Imaging (MRI, CT, PET), EEG, Neuropsychological Testing.

_____

_____

The above information may be disclosed in accordance with the HIPAA Privacy Act.

Signature _____ **Date:** _____