South Coast PSYCHIATRY

Psychotherapy & Medication Management

PATIENT INFORMATION **Today's Date:_____**

Patient Name: _____/_____/_____ /_____
First MI Last Name you like to be called

Patient Address: _____ _____ _____ _____
Street City State Zip

Phone: Home_____ Cell: _____ Work: _____

E-mail address: _____

How may we contact you: Home ___ Cell___ Work___ Email___ (Check all that apply or 'P' for preferred method)

Birth date: _____ Age: _____ Gender: Male ___ Female ___ SS # _____-_____-_____

Ethnicity: Caucasian ____ African-American ____ Asian ____ Hispanic ____ Other _____

Relationship Status: Single ___ Married ____yrs Serious relationship _____yrs Divorced _____yrs

Children? Yes, ages _____ No _____

Occupation/Work address:_____

Student? No ____ Yes, school name_____

Education: _____
(highest level of education, degree, major/specialization)

Financially Responsible Party (if different from patient): _____ _____
Name Relationship

Phone: _____Address: _____ _____ _____ _____
Street City State Zip

How did you first find out about our services?_____

Emergency Care Information

Personal Physician: Name: _____Phone: _____
First Last

Address: _____ _____ _____ _____
Street City State

May we contact your personal physician to discuss medical or medication issues and/or coordinate your care?
No ___ Yes ___ If yes, please complete/sign "Consent" form in attached paperwork.

Family and/or friends to be contacted in an emergency:

Name: _____Relationship_____Phone:_____

Name: _____Relationship_____Phone: _____

Current Concerns

Please provide a brief description of the major concerns that led you to seek treatment/therapy at this time:

_____

_____

_____

Previous Psychiatrist/Therapist

Name of clinician:	Phone Number/Address	Treatment dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe the problems for which you sought therapy in the past: _____

_____

_____

Your experience with previous therapy: Positive ____ Neutral ____ Limited ____ Negative ____

Have you been hospitalized for psychiatric or substance abuse problems? No ___ If yes, please list:
Facility:_____Dates:_____Reason:_____
Facility:_____Dates:_____Reason:_____

Do you have any history of suicide attempts or history of assault? No ___ If yes, please describe:
_____
_____
_____

Medications

Please list all current drugs/medications, including over-the-counter:

Name of medication:	Dose	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any previous psychiatric drugs/medications:

Name of medication:	Dose	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physical Health Status

Do you have any existing medical problems or current physical symptoms of concern to you? If so, please describe.

_____

_____

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:

_____ Date:_____

_____ Date:_____

- Do you smoke? No___ Yes, (#) _____ per day
- Do you drink alcohol? No___ Yes, (# drinks)_____ per week
- Do you engage in any other substance/drug use? No ___ If yes, please explain:_____
- Do you exercise? Regularly____ Occasionally ____ Rarely ____ Never ____
- How is your general food diet? Very healthy____Questionably healthy____ Not very healthy___Changes____
- How is your general health? Excellent ___ Good ___ Fair ___ Poor ___

Family Background

Have any family members had any moderate to severe psychological or medical problems? If so, please describe:

_____

_____

Please describe your family relationships: _____

_____

Social/Occupational/Family Functioning

- Your social network? No close friends ____ One close friend ____ Few friends ____ Many friends _____
- How often do you make contact with friends? Regularly____Occasionally ____ Infrequently____ Never _____
- Are you currently in a romantic relationship? No ___ Yes, it is…… Generally positive ____ Neutral _____ Problematic _____
- Are you able to talk to others about the concerns that bring you into therapy? No____ Yes ____
- What is your living situation? Live alone ____ Live with others, with whom? _____
- How do you feel about (select one) work/school? Pleased _____ Mostly satisfied _____ Mixed _____ Mostly dissatisfied _____ Unhappy _____

Any major dissatisfaction with: Work _____ School _____ Other _____

If so, please explain _____

_____

Please describe any hobbies or recreational activities: _____

_____

_____

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