
*1013 West 2700 South*
*Syracuse, UT 84075*
*1-801-774-7541*

***CONFIDENTIAL PATIENT HISTORY FORM***

Date: _____/_____/_____

Name: _____

Last First M. I.

Age: _____ Sex: Female/Male Birth date: _____/_____/_____

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? Yes/No Have you had psychotherapy? Yes/No

What are your treatment goals?

List three things you struggle with currently and hope to be able to do after therapy.

1.
2.
3.

**CURRENT MEDICATIONS**

Drug allergies: No/Yes To what? _____

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

| **Name of drug** | **Dose** | **How long have you been taking this?** |
|---|---|---|
| | | |
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| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please tell us about other medications, which you no longer take that caused significant side effects or simply did not relieve your symptoms.

1.

2.

3.

4.

5.

**PAST MEDICAL HISTORY**

Do you now or have you ever had:

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

Other medical conditions (please list):

ELEVATED HEALTH

**PERSONAL HISTORY**

Were there problems with your birth? No/Yes (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**

| | Age | Health & Psychiatric | Living or Deceased | Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Siblings: | | | | |
| Children: | | | | |

**Extended Family Psychiatric Problems Past and Present:**

Maternal Relatives:

Paternal Relatives:

**SYSTEMS REVIEW**

In the past month, have you had any of the following problems? **Circle all that apply**

**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
Poor appetite

**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 sexually
Food cravings
Frequent crying
Sensitivity
Thoughts of suicide
Attempts at suicide
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: _____
Menopause: No/Yes at what age? _____ Regular Periods? No/Yes

ELEVATED HEALTH

**SUBSTANCE USE**

| **Drug Category** (Circle each substance used) | **Age when you first used this:** | **How much and how often did you use this?** | **How many years did you use this?** | **When did you last use this?** | **Do you currently use this?** |
|---|---|---|---|---|---|
| **Alcohol** | | | | | **Yes / No** |
| **Cannabis** (Marijuana, hashish, hash oil | | | | | **Yes / No** |
| **Stimulants** (Methamphetamine, speed, ice, crank) | | | | | **Yes / No** |
| **Amphetamines** (Ritalin, Benzedrine, Dexedrine) | | | | | **Yes / No** |
| **Benzodiazepines/Tranquilizers** (Valium, Librium, Halcion, Xanax, Diazepam, "Roofies") | | | | | **Yes / No** |
| **Sedatives/Hypnotics/Barbiturates** (Amytal, Seconal, Dalmane, Quaalude, Phenobarbital) | | | | | **Yes / No** |
| **Heroin** | | | | | **Yes / No** |
| **Street or Illicit Methadone** | | | | | **Yes / No** |
| **Other Opioids** (Tylenol #2 & #3, 282's, 292's, Percocet, Percodan, Opium, Morphine, Demerol, Dilaudid, | | | | | **Yes / No** |
| **Hallucinogens** (LSD, PCP, STP, MDA, DAT, Mescaline, Peyote, Mushrooms, Ecstasy (MDMA), Special K. Nitrous Oxide) | | | | | **Yes / No** |
| **Inhalants** (Glue, Gasoline, Aerosols, Paint thinner, Poppers, Rush, Locker Room) | | | | | **Yes / No** |
| **Other:** (specify) | | | | | **Yes / NO** |