

CONFIDENTIAL Psychiatric / Medical Information Provided by Family / Friend

Date:

Submitted by:

Relationship:

Phone:

Please note that this information was submitted by a family member or friend of the patient for informational purposes only.
This information is to remain confidential and not to be shared with the patient

Name (Last, First, M.I.):

Date of Birth

Marital status: Single Partnered Married Separated Divorced Widowed

PSYCHIATRIC / MEDICAL HEALTH HISTORY

Psychiatric Diagnosis: Please check all diagnosis that apply

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Dual Diagnosis | <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Post-Traumatic Stress Disorder | <input type="checkbox"/> Other (describe below) |

Comments

Other Issues (dates; briefly describe)

Suicide attempts

Violence

Alcohol Abuse

Drug Abuse (List drugs)

History of (or Potential for) Victimization by Other Patients

History of Sexual Abuse or Trauma.

Other / Comments

List Other Medical Problems (E.G. Diabetes, High Blood Pressure, Heart Problems, Seizures Etc.)

Hospitalizations

Year	Reason	Hospital

List Prescribed Drugs

Name the Drug	Dosage	Frequency Taken	Time of Day to be Administered	Prescribing Pharmacy (Name and Location)

Allergies / Negative Reactions to Medications

Name the Drug	Describe Reaction

Psychiatrist

Name:
Address:
Phone:

Physician

Name:
Address:
Phone:

Previous / Present Capabilities and Interests**Other Relevant Information**