MINDPATH HEALTH

Patient Health Screen (Adult)

Patient Last Name: **First Name:** **Date of Birth:**

1. Please state the reason for making this appointment:

2. Have you ever been diagnosed with any psychiatric conditions? ❑ Yes ❑ No *If yes, please list below:

3. Please list all current prescription medication, over the counter medications and/or supplements you are taking:

Medication	Dosage	Taking for how long?	Med helpful? / Concerns

4. Please list past medication that you discontinued and for what reason:

Medication	Dosage	Taking for how long?	Med helpful? / Concerns

5. Please list any allergies to medications:

6. Please list any current medical problems:

7. Please list any major surgeries:

8. Please tell us about your current/past providers:

Do you have a primary care provider?	Have you ever seen a psychiatrist before?	Are you currently seeing a therapist?
❑ Yes ❑ No Dr. Name: Dr. Phone #: Dr. Location: Last visit date:	❑ Yes ❑ No Dr. Name: Dr. Phone #: Dr. Location: Last visit date:	❑ Yes ❑ No Therapist Name: Therapist Phone #: Therapist Location: Last visit date:

9. Have you ever been hospitalized for psychiatric reasons? ❑ Yes ❑ No *If yes, please list below:

Hospital name	City	Admit Date	Discharge Date	Reason for Hospitalization

10. Is there a family history of psychiatric conditions? If yes, please psychiatric condition(s) and your relationship:

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11. Please list your use of:

	Never	Once or Twice	Monthly	Weekly	Daily
Alcohol (For men, 5 or more drinks a day; For women, 4 or more drinks a day)	❑	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑	❑
Prescription Drugs for non-medical reasons	❑	❑	❑	❑	❑
Illegal drugs	❑	❑	❑	❑	❑

12. Please tell us more about yourself:

Education Level:	Employment:	Relationship:	Do you have children?
❑ Less than High School ❑ High School ❑ AA/AS ❑ Bachelors ❑ Masters ❑ Post Grad	❑ Employed ❑ Unemployed ❑ Student ❑ Stay at home parent ❑ Disabled	❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ Yes ❑ No If yes, please list how many:

13. Please list everyone who currently lives with you:

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14. Are you currently dealing with significant financial problems (bankruptcy, foreclosure, large debt, etc.)?

❑ Yes ❑ No *If yes, please list below:

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15. Are you currently dealing with significant legal problems (custody issues, divorce, DUIs, etc.)?

❑ Yes ❑ No *If yes, please list below:

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16. Please list any other information you think is important for the provider to know:

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______________________________ ______________________________
Name of Patient Today's Date

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Patient's Signature