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History Form

Patient's Name: ____________________ Age: ____ Date of Birth:_______ Today's Date__/__/__

Address: ____ City: _______________

State: ____ Zip/Postal Code: _________

How long at this address? _____________

Who referred you to Dr. McGarrahan?

Name: ____________________ Address / phone : ____________________________________

Name of Employer: ______________________________ Work Phone: ____________________

May I contact you at this work #? Yes No May I leave a message? Yes No

Type of Work: __________________________________ Home Phone: __________________

May I contact you at your home #? Yes No May I leave a message? Yes No

E-mail address: _________________________________ Cell Phone: _____________________

May I contact you on your cell phone? Yes No May I leave a message? Yes No

Please describe the problems for which help is needed at this time.

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Have you ever received mental health treatment (including psychotherapy or prescribed psychiatric medication)? No Yes

If yes, please complete the following history of psychiatric/psychological treatment (including psychiatric medication prescribed by a non-psychiatrist physician).

Name of Organization/ Professional	Date	Address

Current Stressors: Please include things such as recent death in family, relationship problems, financial problems, serious medical or psychiatric illness, job problems or unemployment, domestic violence…

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Psychiatric Medication History:

Have you ever taken psychiatric medications?

No If no, please go to page 4 and continue with therapy history.

Yes If yes, please complete the following.

Space is provided, if necessary for up to 6 psychiatric medication periods on the next two pages.

	Medication	**Medication**
Drug Name		
Given by Whom		
When Started		
When Stopped		
For What Problems		
Dose		
Benefits		
Side Effects		

	Medication	Medication
Drug Name		
Provider		
When Started		
When Stopped		
For What Problems		
Dose		
Benefits		
Side Effects		

Therapy History:

Have you ever received mental health related therapy? No Yes

If yes, please complete the following:

Please use the following chart(s) to describe all therapies you have received previously.

	Therapy	Therapy
Type of Therapy		
Provider		
For What Problems		
When Started		
When Stopped		
How Often		
Benefits		
Adverse Reactions		

Family Medical History:

Do medical illnesses run in the family? (examples: seizures, thyroid problems, allergies) No Yes
If yes, please describe:

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Family Psychiatric History:
(Please note any that apply: Major Depression, Bipolar Disorder, Anxiety Disorders, Schizophrenia, Tic Disorders, Substance/Alcohol Abuse, Suicide Attempts, Eating Disorders, or other Psychiatric problems)

Have any of your **biological relatives** had psychiatric problems? No Yes Don't know
If yes, please specify the problem next to the relative.

Mother ______________________________
Father ______________________________
Brother ______________________________
Sister ______________________________
Grandmother ______________________________
Grandfather ______________________________
Aunt ______________________________
Uncle ______________________________

Medical History of Patient: Have you had any of the following? Check any that apply

No	Yes	Don't know		Date(s)
			Measles	
			German Measles	
			Mumps	
			Chicken Pox	
			Whooping Cough	
			Diphtheria	
			Flu	
			Strep Throat	
			Meningitis	
			Encephalitis	
			Hay Fever	
			Abscessed Ears	
			Tubes in Ears	
			Allergy/Asthma	
			Convulsions	
			Head Injuries	
			Other Injuries	
			Other Illnesses	
			Problem with hearing	
			Problem with vision	
			Other	

Do you currently take any medications for a medical illness? No Yes
If yes, please describe: ______________________________

____

______________________________ ______________________________
Signature of person completing form **Date**

______________________________ ______________________________
Signature of person completing form **Date**