DuPont Associates, P.A.
PATIENT MEDICAL AND PSYCHIATRIC HISTORY

Please complete this form carefully. The information you provide is important to your treatment. If you need more space for your answers, use the back of these pages.

1. Name: _____ Date _____
   Last First Middle

2. Give the name, address, and telephone number of someone who knows you well but with whom you are not now living in case we need to contact you for follow-up information:

3. Describe in your own words the major problem for which you are seeking treatment at this time:

4. Have you ever been treated for this, or a similar, problem? ____ Yes ____No
   If yes, what did you find most helpful?

   What did you find least helpful?

5. Who is your personal physician?

   Name: _____

   Address: _____
   Number and Street

   _____
   City State Zip Code

   Phone: _____

6. List other physicians and dentists you have consulted or been treated by in the last three years:

Name	Address	Reason for Care

7. Please list all medications you are NOW taking, the dosage and frequency of each, and indicate whether they have helped you. In indicating how helpful each medication has been, use the following scale:

1 Not at all helpful
2 A little
3 Somewhat
4 Very
5 Extremely helpful

	Drug	Dose	Frequency of use	How long you have used?	For what purpose?	How helpful?
Example	*Valium*	*2 mg.*	*3 times a day*	*5 years*	*Anxiety*	*3*

8. Please list medications you have used IN THE PAST for depression, anxiety, insomnia, or other psychiatric disorders. In indicating how useful each of these medications has been, use the 1-5 scale provided in the previous question.

Drug	Dose	Frequency of use	How long you have used?	For what purpose?	How helpful?

9. Do you smoke cigarettes? _____ Yes _____ No
If yes, now many packs per day?
_____ less than one _____ more than one, but less than two
_____ one _____ two or more

10. Do you drink alcohol?____ Yes ____ No

If yes, indicate the usual frequency of use:

_____ rarely
_____ once or twice a week
_____ daily

If yes, what quantity do you usually drink in any single day?

_____ one drink
_____ two drinks
_____ three drinks
_____ four or five drinks
_____ six or seven drinks
_____ eight or more drinks

11. In the last year, have you used other non-medical drugs? (Examples are cocaine, marijuana). ____ Yes____ No

If yes, list the name, frequency, amount and length of use below:

	Name	Frequency of use	Amount	How long you have used in your lifetime ?
Example	*Marijuana*	*once a week*	*1 joint*	*4 years*

12. IN THE PAST, other than noted above, have you used other drugs non-medically such as cocaine or marijuana?

____ Yes ____ No

If yes, list the name, frequency, amount, and length of use (include dates):

	Name	Frequency of use	Amount	When you used
Example	*Cocaine*	*once a month*	*3 lines*	*6/01-12/04*

13. Have you ever had a drug or alcohol problem or been treated for a substance abuse disorder? ____ Yes ____ No

If yes, describe the problem, when it began, how long it lasted, and what treatment, if any, you have received:

14. Have you ever had a problem with a prescribed medicine, including difficulty stopping use of the medicine?
____ Yes ____ No

    If yes, describe, listing name of medicine(s), problems, and date(s) problem(s) occurred:

15. What is your current weight? _____ lbs.
16. What has been your lowest adult weight? _____ lbs.
17. What has been your highest adult weight? _____ lbs.
18. What is your ideal weight? _____ lbs.
19. What is your height? _____ lbs.
20. Do you exercise regularly? _____ Yes _____ No

    If yes, describe exercise, giving usual frequency and duration of exercise:

21. Is there a history of alcoholism or drug abuse in your family? ____ Yes ____ No

    If yes, check below those family members who have had an alcohol or drug abuse problem:

    _____ mother
    _____ father
    _____ brother or sister
    _____ grandparent(s)
    _____ aunt or uncle
    _____ your son or daughter
    _____ other

    Describe the problem(s):

22. Is there a history of anxiety, depression, bipolar disorder, schizophrenia, or other psychiatric illness in your family which resulted in treatment or hospitalization?

____ Yes ____ No

If yes, please indicate what family member(s) and the diagnosis (or a brief description) for which they were treated:

Family Member	Problem Treated
Mother	
Father	
Brother(s) or Sister(s)	
Grandparent(s)	
Aunt or Uncle	
Your Spouse	
Your Son or Daughter	
Other	

23. Please describe all past and current medical problems you are having/have had other than psychiatric problems:

24. Are you allergic to or have you had adverse reactions to any medications? ____ Yes ____ No
Please list:

25. Have you previously received treatment from a psychiatrist, psychologist, social worker, or other mental health professional? ____ Yes ____ No

If yes, what is the total number of episodes of treatment you have received? That is, how many separate times have you begun treatment? An "episode" is a period of regular visits. For example, if you saw a Therapist for ten sessions in one year and then stopped seeing that Therapist, that would be one "episode" of care.

_____ Episodes of mental health care

26. Approximately how many psychiatric/therapeutic sessions have you had in your lifetime from all therapists combined? Estimate the total number of visits in your lifetime to a psychiatrist ,psychologist or social worker.

_____ sessions

27. Please list below the mental health providers you have worked with, the dates and lengths of treatment and reason for each treatment episode:

	Name of Therapist	Dates of Treatment	Number of Sessions	Reason for Treatment
Example	*Dr. James Brown*	*Aug'08 - Sept.'08*	*100*	*depression and fear of flying*

28. Have you ever been hospitalized for a mental health problem? ____ Yes ____ No

If yes, indicate the number of separate hospital admissions

_____ Admissions

29. Please list hospitalizations below:

Name of Hospital	Dates of Hospitalization	Reasons for Hospitalization

30. What time do you normally go to bed? _____
What time do you normally get out of bed: _____
Do you have a problem with insomnia? _____ Yes _____ No

If yes, describe your insomnia:

31. How many close friends do you have to whom you confide things, even if they are embarrassing or upsetting?

_____

32. Do you feel you are now under unusual stress in your life? ____ Yes ____ No

If yes, describe

33. Think about living your life just the way you want to live it.
What would you have to change for you to achieve this goal?

34. In order for you to conclude that your treatment here was fully successful, what would you want to achieve (e.g., what are your goals for your care with us at this time)?

35. Are there other facts about you that you think we should know to be better able to help you?

Thank you for your help.