



**School Information**

**Work Information**

Name		Occupation
Address		Company
		Address
Guidance	Phone	
Psychologist	Phone	Phone
Social Worker	Phone	Fax

**Family members residing in the home**

Name	DOB	Age	Gender	Relationship
			M F	
			M F	
			M F	
			M F	
			M F	

**Mental Health History**

**Hospitalizations** • Yes • No If yes, how many? \_\_\_\_\_

Hospitals	Date	Reason

**Psychotherapy – (Current and Past)**

Clinician Name: \_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_

Type: MD or PhD or SW or Masters Phone: \_\_\_\_\_

Clinician Name: \_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_

Type: MD or PhD or SW or Masters Phone: \_\_\_\_\_

Clinician Name: \_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_

Type: MD or PhD or SW or Masters Phone: \_\_\_\_\_

**Prescriber** – Physician or Nurse Practitioner (*Current and Past*)

Clinician Name: \_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_

*Type:* Psychiatrist or Family Physician or Pediatrician or Nurse Practitioner

Phone: \_\_\_\_\_

Clinician Name: \_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_

*Type:* Psychiatrist or Family Physician or Pediatrician or Nurse Practitioner

Phone: \_\_\_\_\_

**Psychiatric Medication History**

**Current Psychiatric Medications** • Yes • No

Medication	Dose	Start Date	Side Effects

**Previous Psychiatric Medications** • Yes • None

Medication	Dose	Start Date	Stop Date	Reason for stopping

**Medical History**

**Primary Care Doctor**

Name	Phone
Address	Fax

**Medical or Surgical History**

Medical Diagnosis or Surgery	Date Diagnosed	Treating Physician	
		Name	Phone

**Current Medications** (*other than psychiatric*)

Medication	Dose	Start Date	Treating Diagnosis	Side Effects

**Allergies** • None • Yes (*see below*)

**Medication Allergies**

Name	Reaction

**Food Allergies**

Name	Reaction

**Other Allergies**

Name	Reaction

**Family History of Mental Health Disorders** *(Leave blank if not applicable)*

<b>Diagnosis</b>	<b>Relationship to Patient</b>	<b>Treated or Untreated</b>
Alcohol Abuse/Dependence		
Anger Problems		
Anxiety <i>(Generalized or Panic Disorder)</i>		
Attention Deficit Hyperactivity		
Autism		
Behavior/Conduct Problems		
Bipolar Disorder		
Depression		
Eating Disorders		
Gambling Problems		
Learning Disorders		
Mental Retardation		
Obsessive Compulsive (OCD)		
Schizophrenia		
Suicide - Attempts		
Suicide - Completed		
Substance Abuse		
Tic Disorder		
<i>Other</i>		
<i>Other</i>		

**Reason for seeking treatment** *(In Brief)*

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*Thank you for your time in completing this form. All of the information will help Dr. Schwartz provide a thorough and comprehensive assessment. Any additional information not covered in this form that you think is helpful and important information, please feel free to detail it below.*

Additional Information *(If applicable)*