**Mental Health History Form**

**Client Name:**

**Date of Birth:**

**Pharmacy Used:**

**Primary Care Provider:**

**Last Physical:**

1. What is happening that you are seeking a medication evaluation at this time?
2. Have you previously, or are you currently, seeing a therapist? If so, how often are the sessions occurring?
3. Is there any history of self-harming behaviors? If so, please describe.
4. Is there any history of physical aggression? If so, please describe?
5. Is there any history of psychiatric hospitalizations (inpatient, CBAT, Partial)? If so, what were the (approximate dates and locations) of the treatments(s)?
6. What substances (tobacco, CBD oil, marijuana, alcohol, etc.) are currently being used?
7. Have you previously seen another prescriber? If so, when was the last appointment?
8. Please list past and current psychiatric medications and if possible who is prescribing them:

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| Past Medications | Name | Prescriber | Any reactions |
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| Current Medications | Name | Prescriber | Any reactions |
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\*\*If you need additional space, please use the back of the paper\*\*

1. Do you have any safety concerns at this time? (Are there thoughts of self-harm or harm to others)
2. Are you currently being treated for any medical issues (i.e. anemia, diabetes, asthma, thyroid issues, gastrointestinal issues, etc.) and if so what medications are you currently taking?
3. Are there any allergies to foods/medications/environmental factors? This is particularly important as I have a dog that is in the office for the majority of the time that I see clients.
4. Are there any specific schedule restrictions or other factors that are important to know (i.e. specific religious celebrations, cultural needs).
5. Is there any other information that it would be important for me to know in working together?

***Thank you for completing this form.***