KIC
BEHAVIORAL & COUNSELING SERVICES

PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ☐F ☐ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: ☐No ☐Yes To what?
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Physician initials _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS

Other medical conditions (please list):

_____

_____

_____

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ☐ High school ☐ Some college ☐ College graduate ☐ Advanced degree

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ☐ Yes ☐ No Hours/week _____ If not, are you ☐ retired ☐ disabled ☐ sick leave?

Do you receive disability or SSI? ☐ Yes ☐ No If yes, for what disability & how long?_____

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

Physician initials _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ☐ Recent weight gain; how much____
- ☐ Recent weight loss: how much____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES
- ☐ Numbness
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

Where?

EARS
- ☐ Ringing in ears
- ☐ Loss of hearing

EYES
- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness

THROAT
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw

HEART AND LUNGS
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen legs or feet
- ☐ Cough

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling
- ☐ Memory loss

STOMACH AND INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

SKIN
- ☐ Redness
- ☐ Rash
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet

BLOOD
- ☐ Anemia
- ☐ Clots

KIDNEY/URINE/BLADDER
- ☐ Frequent or painful urination
- ☐ Blood in urine

Women Only:
- ☐ Abnormal Pap smear
- ☐ Irregular periods
- ☐ Bleeding between periods
- ☐ PMS

PSYCHIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulties with sexual arousal
- ☐ Poor appetite
- ☐ Food cravings
- ☐ Frequent crying
- ☐ Sensitivity
- ☐ Thoughts of suicide / attempts
- ☐ Stress
- ☐ Irritability
- ☐ Poor concentration
- ☐ Racing thoughts
- ☐ Hallucinations
- ☐ Rapid speech
- ☐ Guilty thoughts
- ☐ Paranoia
- ☐ Mood swings
- ☐ Anxiety
- ☐ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Ⓨ/ Ⓝ At what age?
Do you have regular periods? Ⓨ/ Ⓝ

Physician initials _____

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, hashish, hash oil					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine—speed, ice, crank					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes □ No □
HEROIN					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes □ No □
OTHER: specify)_____ _____ _____					Yes □ No □

Physician initials _____