BRIEF HISTORY

LIST THE NAME AND DOSE OF ALL MEDICATIONS YOU CURRENTLY TAKE:

LIST ANY MEDICATION ALLERGIES YOU HAVE:

LIST ANY PSYCHIATRIC MEDICATIONS YOU HAVE TAKEN IN THE PAST:

HAVE YOU HAD INPATIENT OR OUTPATIENT MENTAL HEALTH TREATMENT IN THE PAST:
NO YES WHEN

LIST ANY SURGERY, CHRONIC ILLNESS/MEDICAL PROBLEM YOU HAVE NOW, OR HAVE HAD IN THE PAST:

LIST ANY BLOOD RELATIVES THAT HAVE PROBLEMS WITH:
DRUG /ALCOHOL ABUSE:

DEPRESSION/ANXIETY:

DO YOU SMOKE: NO YES WHEN DID YOU QUIT?

HOW MUCH CAFFEINE DO YOU USE?

HOW MUCH ALCOHOL DO YOU DRINK?

DRINK TO DRUNKENESS? NO YES DRINK TO BLACKOUT? NO YES
DUI? NO YES

WHAT STREET DRUGS HAVE YOU USED OR TRIED? WHEN DID YOU LAST USE?