Transitions Center
Integrative Psychiatry & Addiction Treatment

Clinical History- Patient Section

Medical Record #_____

ALLERGIES YES / NO If Yes, Details

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Allergy _____ Reaction _____

Current Psychiatric Medications (Yes/No) If Yes, Details

Drug Name: _____ Dose: _____ How long? _____ Effective? _____

Side-effects/details: _____ Comments: _____

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Drug Name: _____ Dose: _____ How long? _____ Effective? _____

Side-effects/details: _____ Comments: _____

Drug Name: _____ Dose: _____ How long? _____ Effective? _____

Side-effects/details: _____ Comments: _____

Past Psychiatric Medications (Yes/No) If Yes, Details

Drug Name: _____ Dose: _____ How long? _____ Effective? _____

Side-effects/details: _____ Comments: _____

Drug Name: _____ Dose: _____ How long? _____ Effective? _____

Side-effects/details: _____ Comments: _____

Drug Name: _____ Dose: _____ How long? _____ Effective? _____

Side-effects/details: _____ Comments: _____

Drug Name: _____ Dose: _____ How long? _____ Effective? _____

Side-effects/details: _____ Comments: _____

Other Past Psychiatric Treatments (Yes/No) If Yes, Details

ECT, VNS, TM Yes / No Comments: _____

Psychotherapy Yes / No Comments: _____

Non-Psychiatric Medications/Supplements/Vitamins

Name: _____ Dose: _____ Name: _____ Dose: _____

Name: _____ Dose: _____ Name: _____ Dose: _____

Name: _____ Dose: _____ Name: _____ Dose: _____

Name: _____ Dose: _____ Name: _____ Dose: _____

Medical History (Yes/No) If Yes, Details

Anemia/Blood Disorders	Yes / No	_____
Cancer	Yes / No	_____
Chronic Pain/Chronic Fatigue	Yes / No	_____
Delirium/Dementia	Yes / No	_____
Head trauma	Yes / No	_____
Heart Disease/High Blood Pressure	Yes / No	_____
HIV/AIDS	Yes / No	_____
Liver Disease	Yes / No	_____
Multiple Sclerosis/Parkinson's	Yes / No	_____
Thyroid abnormalities	Yes / No	_____
Other Chronic Illnesses or Disability	Yes / No	_____
Seizures	Yes / No	_____
Toxins/heavy metal exposures	Yes / No	_____

Past Psychiatric Treatment (Yes/No) If Yes, Details

First Psychiatric Treatment: _____

Prior Diagnoses (if known): _____

Self-Harming Behaviors: _____

Aggressive/Assaultive Behaviors: _____

Psychiatric hospitalizations: _____

Comments: _____

_____

_____

Substance Use History (Yes/No) If Yes, Details

Tobacco [ ] NO [ ] YES; Details_____

Alcohol [ ] NO [ ] YES; Details_____

Opiates (street or Rx) [ ] NO [ ] YES; Details_____

Benzodiazepines [ ] NO [ ] YES; Details_____

Cocaine [ ] NO [ ] YES; Details_____

Meth [ ] NO [ ] YES; Details_____

Stimulants [ ] NO [ ] YES; Details_____

Hallucinogens/Ecstasy [ ] NO [ ] YES; Details_____

Marijuana [ ] NO [ ] YES; Details_____

H/O Intravenous Drug Use [ ] NO [ ] YES; Details_____

Family History (Yes/No) If Yes, Details

Medical: [ ] NO [ ] YES; Details_____

Psychiatric/Mental Health: [ ] NO [ ] YES; Details_____

_____

Suicides: [ ] NO [ ] YES; Details_____

Alcohol/Substance Abuse: [ ] NO [ ] YES; Details_____

_____

Psychosocial History

Childhood/Adolescence History (Where born and raised? Number of siblings? Parents married, remained together or separated, divorced while growing up? Household environment while growing up? Social life outside of family?)

_____

_____

_____

_____

History of Abuse/Trauma? (May answer only Yes/No if don't want to share details)

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School/academics/diplomas/degrees (School performance, Total years of schooling, Diploma(s)/Degree(s), Relationship with teachers/peers, etc.)

Relationships/sexual orientation/marriages/children (Provide as many details as you are comfortable with)

Employment History/Current employment status

Living Situation (Have permanent residence? Own/rent? Living alone/with roommates/family, significant other, etc.)

Support System (Who/what are your main supports: family, friends, significant other/partner, coworkers, church, spiritual circle, etc.)

Military/Legal History (Ever served in military? how long? exposure to combat? Type of discharge? Any history of legal problems, incarcerations, probations, etc.)