MENTAL HEALTH SUMMARY

Patient Name_____Occupation_____DOB_____
Address _____ zip code_____
Home phone _____cell _____ work_____
Emergency contact person _____ Phone _____

Psychiatric History

Treatment history

Past Inpatient: no_____ yes_____ *(If yes, #_____ dates* _____

Past Outpatient: no____ yes_____ *(If yes, #_____ dates* _____

Substance Abuse Outpatient: no____ yes____ *(If yes, #_____ dates*_____

Inpatient: no_____ yes_____ *(If yes, #_____dates* _____

Psychiatric Problems

Depression: no____ yes____ Suicidal: no___ yes___

In family: no_____ yes_____ (Relationship _____

Substance Abuse: no_____ yes_____ (Substances _____

_____

In family: no_____ yes_____ (Relationships_____

_____

Eating Disorder: no_____ yes_____

Abuse History (circle if appropriate)

Physical Sexual Emotional Neglect

Human Service Involvement *(circle)*

DSS DMH DYS Other_____

Pertinent Medical Problems, Conditions, Accidents

Condition or incident: _____ date_____

_____ date_____

_____ date_____

Medications _____

_____

Allergies to food or medication: no_____ yes_____ If yes, list _____

_____

Potential Health Hazards

cigarette smoker: no_____ yes_____

safe sex: no_____ yes_____