willow tree
Psychiatry llc

PATIENT INFORMATION

Name:		Date:
Date of Birth:	Age:	Gender: ☐ Male ☐ Female ☐ Other
Primary Phone:		Email Address:

Home Address:

Contact Person: Relationship:

☐ Share Medical Information ☐ Contact ONLY in Emergency

Ethnicity:

☐ Native American ☐ White ☐ Black ☐ Hispanic

☐ Native Islander ☐ Asian ☐ Native Alaskan ☐ Other: _____

PHYSICIAN INFORMATION

Primary Physician:

Who Referred You to Us?

☐ Dr._____ ☐ Family ☐ Friend ☐ Internet

☐ Other: _____

REASON FOR VISIT

☐ Finding a New Psychiatrist ☐ Second Opinion ☐ Changing Medications ☐ Personal Therapy

☐ Relationship Therapy ☐ Medications ☐ Other: _____

MEDICAL HISTORY

Allergies to Medications:

☐ Yes ☐ No If yes, list:

Previous or Current Medical Diagnosis:
☐ Yes ☐ No If yes, list:

Previous or Current Psychiatric Diagnosis:
☐ Yes ☐ No If yes, list:

Current Medications or Herbal Treatments:
☐ Yes ☐ No If yes, list:

Past Medical or Psychiatric Hospitalizations:
☐ Yes ☐ No If yes, list:

Previous Psychotherapy:
☐ Yes ☐ No If yes, when & outcome:

Past Suicide Attempts:
☐ Yes ☐ No If yes, date & method:

Recent Changes in Your Health:
☐ Yes ☐ No If yes, explain:

Recent Changes in Weight:
☐ Yes ☐ No If yes, list:

Do you have any cultural practices that may affect your treatment?
☐ Yes ☐ No If yes, explain:

Do you have any religious practices that may affect your treatment?
☐ Yes ☐ No If yes, explain:

Do you have any of the following:			
	☐ Emphysema	☐ Kidney Disease	☐ Heart Disease
	☐ Asthma	☐ STD	☐ Thyroid Disease
	☐ TB	☐ Glaucoma	☐ Head Injury
	☐ Hypertension	☐ Diabetes	

SOCIAL HISTORY

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:

Do you have Children?
☐ Yes ☐ No If yes, ages:

Do you have Siblings:
☐ Yes ☐ No If yes, ages:

Education beyond high school:
☐ Yes ☐ No If yes, degrees obtained:

Current Occupation:

Weapons in home:
☐ Yes ☐ No If yes, identify:

Do you exercise?
☐ Yes ☐ No If yes, how often:

Traumatic Life Events: ☐ Yes ☐ No If yes, list:			
Arrests or Legal Issues: ☐ Yes ☐ No If yes, list:			
Current Sources of Stress: ☐ Yes ☐ No If yes, list:			
Do you use any of the following:	☐ Tobacco ☐ Caffeine ☐ Alcohol ☐ Cannabis	☐ Cocaine ☐ Hallucinogens ☐ Methamphetamine ☐ Heroin	☐ CBD ☐ Other_____

FAMILY HISTORY

Does anyone related to you by blood have any of the following:	☐ Depression ☐ Bipolar Disorder ☐ Alcoholism ☐ Anxiety ☐ Dementia ☐ Eating Disorder ☐ Drug Use ☐ Impulse Issues	☐ Schizophrenia ☐ Social Phobia ☐ Panic Disorder ☐ PTSD ☐ Suicide ☐ Seizures ☐ Strokes ☐ Multiple Sclerosis	☐ Brain Tumors ☐ Endocrine Disorder ☐ Heart attack ☐ Neurologic Conditions ☐ ADHD ☐ Other_____

ADDITIONAL SCREENING

Do you regularly:	☐ Feel Nervous ☐ Have repeating thoughts ☐ Worry ☐ Have trouble sleeping ☐ Have trouble relaxing ☐ Become irritable ☐ Feel afraid for no reason ☐ Have impulse Issues	☐ Feel lethargic ☐ Feel hyper ☐ Lose interest ☐ Relive negative events ☐ Feel cut off from people ☐ Engage in reckless sex ☐ Fantasize about death ☐ Have difficulty focusing	☐ Take unnecessary risks ☐ Hurt yourself ☐ Feel abandoned ☐ Feel distrustful ☐ Feel bored ☐ Get distracted ☐ Delay projects ☐ Feel misplace things

Signature of person completing this form _____

Printed name of person completing this form _____