Via Clinic

Private Practice Psychiatry and Psychotherapy
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PATIENT HISTORY FORM

This form has been provided so that your initial appointment will be most beneficial to you. Please fill out and return prior to your appointment. It may be securely returned by email at *Via@ViaClinicMD.com*, faxed to *(844) 308-8872*, or mailed to the office address. You may also bring it with you, though it is most helpful for Via Clinic to review prior to the appointment.

Use the additional notes section on page 4, as needed.

Date _____ Name of patient _____

Name of person filling out this form *(if different than the patient)* _____

Please describe the principal reason you are seeking consultation or treatment._____

_____

_____

_____

FAMILY HISTORY

(Yes/no – if yes, please describe and include any known active or previous medication treatment)

Does anyone in your immediate or extended family have a history of suspected, diagnosed or treated mental illness, including substance abuse?

☐ *yes* ☐ *no* ☐ *unsure* *If yes,* _____

Is there any family history of suicides? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

Is there any family history of bipolar or schizophrenia? ☐ *yes* ☐ *no* ☐ *unsure*

If yes,

Is there any family history of psychiatric hospitalizations? ☐ *yes* ☐ *no* ☐ *unsure*

If yes,

CHILDHOOD HISTORY

Were there any complications with your birth? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

Were you ever diagnosed with a learning disorder? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

Were you ever diagnosed with attention deficit/hyperactivity disorder (ADHD)? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

Were there any delays in reaching motor or social milestones? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

Were you ever suspended or expelled from school? ☐ *yes* ☐ *no*

If yes, _____

Did you ever have an independent education plan (IEP)? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

Were there any disruptions in your childhood education, such as grade repeats or significant absence from school? ☐ *yes* ☐ *no*

If yes, _____

SOCIAL HISTORY

Highest level of education ________ Current or former occupation ________

Marital status ________ Number of children ________ How many people reside in your household ________

Religious affiliation (if any) ________

Do you have any history of significant legal stresses? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, ________

Is there a gun in your home? ☐ *yes* ☐ *no*

MEDICAL HISTORY

Do you have any personal history of *(check all that apply)*:

- ☐ *head trauma*
- ☐ *loss of consciousness*
- ☐ *seizures*
- ☐ *pseudoseizures/non-epileptic seizures*
- ☐ *stroke*
- ☐ *glaucoma*
- ☐ *cataracts*
- ☐ *asthma*
- ☐ *COPD*
- ☐ *obstructive sleep apnea*
- ☐ *restless leg syndrome*
- ☐ *tremor*
- ☐ *skin problems*
- ☐ *diabetes*
- ☐ *high blood pressure*
- ☐ *high cholesterol*
- ☐ *gastric surgery*
- ☐ *heart failure*
- ☐ *heart attack*
- ☐ *coronary artery disease (CAD)*
- ☐ *kidney stones*
- ☐ *hepatitis*
- ☐ *HIV/AIDS*
- ☐ *hypothyroidism*
- ☐ *cancer*
- ☐ *other (please list)* ________ ________

PRIMARY CARE PHYSICIAN

____

DRUG ALLERGIES/ADVERSE REACTIONS

List drug allergies or adverse drug reactions, and describe the reaction.

Drug allergy/adverse drug reaction ________ *Reaction* ________

Drug allergy/adverse drug reaction ________ *Reaction* ________

Drug allergy/adverse drug reaction ________ *Reaction* ________

CURRENT MEDICATIONS

List medication, dose, number of pills per day, prescriber, and date started.

Medication ________ *Dose* ________ *# Pills/day* ________ *Prescriber* ________ *Since* ________

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Medication ________ *Dose* ________ *# Pills/day* ________ *Prescriber* ________ *Since* ________

PSYCHIATRIC MEDICATION HISTORY

List any prior medications, other than those listed above, prescribed for psychiatric purposes. Include the dose, number of pills per day, prescriber, and dates taken.

Medication ________ *Dose* ________ *# Pills/day* ________ *Prescriber* ________ *Dates taken* ________

Medication ________ *Dose* ________ *# Pills/day* ________ *Prescriber* ________ *Dates taken* ________

Medication ________ *Dose* ________ *# Pills/day* ________ *Prescriber* ________ *Dates taken* ________

Medication ________ *Dose* ________ *# Pills/day* ________ *Prescriber* ________ *Dates taken* ________

Medication ________ *Dose* ________ *# Pills/day* ________ *Prescriber* ________ *Dates taken* ________

PSYCHIATRIC HOSPITALIZATIONS

List the location, year, and duration of any prior hospitalizations.

Location/hospital ________ *Year* ________ *Duration* ________

Location/hospital ________ *Year* ________ *Duration* ________

Location/hospital ________ *Year* ________ *Duration* ________

Location/hospital ________ *Year* ________ *Duration* ________

Location/hospital ________ *Year* ________ *Duration* ________

PSYCHOTHERAPY

List dates of previous psychotherapy, as well as the name and address of the therapist.

Therapist name _____ *Location* _____ *Dates Seen* _____

Therapist name _____ *Location* _____ *Dates Seen* _____

Therapist name _____ *Location* _____ *Dates Seen* _____

Therapist name _____ *Location* _____ *Dates Seen* _____

Therapist name _____ *Location* _____ *Dates Seen* _____

OTHER PSYCHIATRIC HISTORY

Have you ever had a suspected or diagnosed eating disorder? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

Have you ever had a suspected or diagnosed gambling disorder? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

Have you ever had a suspected or diagnosed sexual disorder? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

SUBSTANCE USE

Have you ever used any of the following? *If yes, list date of last use. For prescription medications, check only if you used this when it was NOT prescribed to you.*

☐ *Tobacco/nicotine* _____
☐ *caffeine* _____
☐ *alcohol* _____
☐ *Cannabis (marijuana)* _____
☐ *synthetic cannabinoids (e.g. K2, spice)* _____
☐ *cocaine (crack)* _____
☐ *methamphetamine* _____
☐ *non-prescribed stimulants (e.g. Adderall,Ritalin)* _____
☐ *heroin* _____
☐ *other opiates/opioids (e.g, oxycodone, hydrocodone, morphine, methadone, buprenorphine)* _____
☐ *sedatives (e.g. Librium, Valium, Xanax, phenobarbital)* _____
☐ *MDMA (e.g. ecstasy/molly)* _____
☐ *hallucinogens (e.g. LSD, PCP, psilocybin/mushrooms, mescaline/peyote, DMT, ketamine)* _____
☐ *inhalants (e.g. glues, aerosols, poppers)* _____
☐ *synthetic cathinones (e.g. bath salts/flacca)* _____
☐ *other (please list)* _____

WOMEN'S REPRODUCTIVE HISTORY

Age at first period _____ Number of pregnancies resulting in live birth _____

Number of stillbirths *(or loss after 20 weeks gestation)* _____

Number of spontaneous abortions *(miscarriages)* _____ Number of elective abortions _____

Have you experienced any significant mood symptoms that started within 4 weeks of delivery or pregnancy termination?
☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

Have you ever used a hormone birth control method *(pills, Nuva Ring, Patch, IUD),* other hormone treatment *(such as for polycystic ovarian syndrome or missed menses)* or hormone replacement therapy (HRT)? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, _____

Have you reached menopause? ☐ *yes* ☐ *no* ☐ *unsure*

If yes, what age _____

Do you have irregular periods? ☐ *yes* ☐ *no* ☐ *unsure*

Do moods/depression/irritability correlate with your menstrual cycle? ☐ *yes* ☐ *no* ☐ *unsure*

If yes,

REVIEW OF SYSTEMS

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

General

- ☐ *Recent weight gain: how much* _____
- ☐ *Recent weight loss: how much* _____
- ☐ *Fatigue*
- ☐ *Fever*
- ☐ *Night sweats*

Muscle/Joints/Bones

- ☐ *Numbness: where* _____
- ☐ *Joint pain: where* _____
- ☐ *Muscle weakness: where* _____
- ☐ *Joint swelling: where* _____

Ears

- ☐ *Ringing in ears*
- ☐ *Loss of hearing*

Eyes

- ☐ *Redness*
- ☐ *Loss of vision*
- ☐ *Double or blurred vision*
- ☐ *Dryness*

Throat

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

Blood

- ☐ *Anemia*
- ☐ *Clots*

Heart & 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 & Intestines

- ☐ *Nausea*
- ☐ *Heartburn*
- ☐ *Stomach pain*
- ☐ *Vomiting*
- ☐ *Increasing constipation*
- ☐ *Persistent diarrhea*
- ☐ *Blood in stools*
- ☐ *Black stools*

Skin

- ☐ *Rash*
- ☐ *Hair loss*
- ☐ *Color changes of hands or feet*

Kidney/Urine/Bladder

- ☐ *Frequent or painful urination*
- ☐ *Blood in urine*

Psychiatric

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

Women Only

- ☐ *Abnormal Pap smear*
- ☐ *Abnormal mammogram*
- ☐ *Bleeding between periods*

ADDITIONAL NOTES