Silver Psychiatric Services

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PATIENT INFORMATION

Date of 1st Appointment: _____ **Today's Date:** _____
Patient Name: _____ **Male** ☐ **Female** ☐
Date of Birth: _____ **Place of Birth :** _____ **Age:** ___ **Religious Affiliation:** _____
Home Phone: _____
Address: _____

Employer: _____ **Occupation:** _____
Business Phone: _____ **Cell Phone:** _____

Education: Years Completed: _____ Degrees Obtained: _____

Marital Status: Single Married Separated Divorced Widowed
Name of Spouse/Significant Other: _____
Date of Birth: _____ Occupation: _____
Education: Years Completed: _____ Degrees Obtained: _____
Date and place of Marriage: _____
Previous Marriages and Children: _____
If divorced, Custodial Parent: _____
Marital Problems? _____

List below all people residing in your home:

Name	Relationship or Status in Home	Birthdate & Age	School Grade or Occupation
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

How were you referred? _____

What events or Circumstances prompted you to call at this time? _____
_____
Describes what you believe has caused the difficulties you are having? _____
_____
_____
What have you done to help these problems? _____
_____
_____
Have you sought professional help before? From whom and for what? Was it helpful? (Examples of professional help might be a social agency such as Family and Children's Service, a hospital, a psychologist, a social worker, a counselor, a psychiatrist.) _____
_____
Family or Personal history of Suicide Attempts? _____
_____

Describe any family difficulties or events which were upsetting (such as: illness or death of a family member or close relative, moves, financial problems, marital stress, sexual or physical abuse). _____
_____
_____

Medical History

Date of most Recent Physical Exam: _____ Results: _____
Please provide the name and address of your physician or medical clinic: _____
Name: _____ Phone: _____

Address: _____

_____

Are you now receiving treatment? _____

List below serious illnesses, accidents, or operations which you have had. Give the date of the illness or injury, and if you were hospitalized, give the name of the hospital, approximate length of stay, and the attending physician.

_____
_____
_____

Medications? (Please list current name dosage and frequency) Please include over the counter and herbal

_____
_____
_____
_____
_____
_____
_____

Allergies?

_____

Family History:
Describe any medical or psychiatric conditions of your parents, siblings and children: _____

_____
_____
_____

Habits:	**Amount currently using**	**Most ever used**
Coffee (cups/day)	_____	_____
Cigarettes (packs/day)	_____	_____
Alcohol	_____	_____

Psychiatric History
Have you ever received psychiatric or psychological treatment of any kind before? Yes No

If you checked yes to the above question please answer the following:
What type of care did you receive? Inpatient (hospital) Outpatient Both
Where were you in treatment?

_____
_____

When were you in treatment? _____
How long were you in treatment? _____
Who was your therapist or doctor? _____
Did your doctor prescribe Medicine at that time? Yes No Not applicable
If yes what was prescribed (include dosage if know)? _____

_____
_____
_____

Substance Use History
Have you ever abused drugs or alcohol? Yes No

If yes please describe:

Substances	Amount	Frequency	When? (First use; Last use)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If yes have you ever received substance abuse treatment of any kind? Yes No

Do you have a history of blackouts, seizures or withdrawal symptoms? _____

_____

Please describe anything else you would like your clinician to know? _____

_____

_____

_____

_____

Insurance Information: _____

Social Security#/ Insurance ID #: _____

Insurance Plan: _____

Main Policy Holder: _____

Pharmacy #: _____