Desoto Family Counseling
& Pediatric Therapy Center
FINDING SILVER LININGS SINCE 2001

Adult Medical History

Today's Date: _____

Please complete this form in its entirety to the best of your ability. If you have any questions or concerns, please do not hesitate to ask the receptionist or another staff member to assist you. Thank you.

Patient name: _____ DOB: _____

Chief complaint for medication management. Please include the amount of time this problem has been persisting:

_____

Medication and/or Food Allergies: _____No known allergies

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Current Medications prescribed to the patient. Please include the prescribing physician.

Medication	Dose	Quantity	Frequency	Use

Primary care physician name and number: _____

Last appointment with primary care: _____ Was bloodwork done? _____

Please review the following list of medications commonly prescribed for a psychiatric diagnosis. If you have taken or are currently taking any of these medications, please fill out the specific boxes related to that medication.

Brand Name	Generic Name	Currently taking?	Tried in the past?	Dosage prescribed?	How often in a day?	How long did you take it?	Any side effects?
Anafranil	Clomipramine						
Asendin	Amoxapine						
Ativan	Lorazepam						
Buspar	Buspirone						
Catapres	Clonidine						
Celexa	Citalopram						
Cymbalta	Duloxetine						
Effexor	Venlafaxine						
Elavil	Amitriptyline						
Klonopin	Clonazepam						
Lexapro	Escitalopram						
Librium	Chlordiazepoxide						
Luvox	Fluvoxamine						
Neurontin	Gabapentin						
Pamelor	Nortriptyline						
Paxil	Paroxetine						
Pristiq	Desvenlafaxine						
Prozac	Fluoxetine						
Remeron	Mirtazapine						
Rexulti	Brexpiprazole						
Silenor	Doxepin						
Tofranil	Imipramine						
Tranxene	Clorazepate						
Trintellix	Vortioxetine						
Valium	Diazepam						
Viibryd	Vilazodone						
Wellbutrin	Bupropion						
Xanax	Alprazolam						
Zoloft	Sertaline						

Brand Name	Generic Name	Currently taking?	Tried in the past?	Dosage prescribed?	How often in a day?	How long did you take it?	Any side effects?
Antabuse	Dizulfiram						
Campral	Acamprosate						
Naltrexone	Revia						
Methadone	Methadose						
Suboxone	Buprenorphine						

Please review the following list of medications commonly prescribed for a psychiatric diagnosis. If you have taken or are currently taking any of these medications, please fill out the specific boxes related to that medication.

Brand Name	Generic Name	Currently taking?	Tried in the past?	Dosage prescribed?	How often in a day?	How long did you take it?	Any side effects?
Abilify	Aripiprazole						
Artane	Trihexyphenidyl						
Caplyta	Lumateperone						
Clozapine	Clozapine						
Cogentin	Benztropine						
Depakote	Valproate						
Fanapt	Iloperidone						
Geodon	Ziprasidone						
Haldol	Haloperidol						
Invega	Paliperidone						
Lamictial	Lamotrigine						
Latuda	Lurazidone						
Lithium	Eskalith						
Navane	Thiothixene						
Prolixin	Fluphenazine						
Risperidal	Risperidone						
Saphirs	Asenapine						
Tegretol	Cabamezepine						
Thorazine	Chlorpromazine						
Vraylar	Cariprazine						
Zyprexa	Olanzapine						

Please review the following list of medications commonly prescribed for a psychiatric diagnosis. If you have taken or are currently taking any of these medications, please fill out the specific boxes related to that medication.

Brand Name	Generic Name	Currently taking?	Tried in the past?	Dosage prescribed?	How often in a day?	How long did you take it?	Any side effects?
Ambien	Zolpidem						
Desyrel	Trazdone						
Hydroxyzine	Vistaril						
Lunesta	Eszopiclone						
Prazosin	Minipress						
Seroquel	Quetiapine						

Please review the following list of medications commonly prescribed for a psychiatric diagnosis. If you have taken or are currently taking any of these medications, please fill out the specific boxes related to that medication.

Brand Name	Generic Name	Currently taking?	Tried in the past?	Dosage prescribed?	How often in a day?	How long did you take it?	Any side effects?
Adderall	Amphetamine						
Adzenys	Amphetamine						
Concerta	Methylphenidate						
Dexedrine	Amphetamine						
Dyanavel	Amphetamine						
Evekeo	Amphetamine						
Focalin	Methylphenidate						
Intuniv	Guanfacine						
Procentra	Amphetamine						
Ritalin	Methylphenidate						
Strattera	Atomoxetine						
Vyvanse	Lisdexamfetamine						

Family Medical History:

Please check (√) any of the following conditions that anyone in the patient's immediate family has been diagnosed with.

Conditions:	Self	Mother	Father	Sibling	Child	Grandparent
ADHD						
Alcohol Problems						
Anxiety						
Autism/Asperger						
Bipolar						
Depression						
Drug Problems						
Panic Attacks						
Psychiatric hospital stay(s)						
PTSD						
Schizophrenia						
Suicide attempts						

Women Only:

Age of first menses: _____ Age menses stopped: _____Total Pregnancies: _____

Live Births: _____ Miscarries/Terminations: _____ Living Children: _____

Past Medical History:

Please check (√) any of the following conditions that the patient has been diagnosed with.

____Anemia/bleeding problems	____Eye disorder	____ Low Blood Pressure
____Arthritis	____Head Trauma	____Neurological problems
____Asthma	____Heartburn/reflux	____ Restless leg syndrome
____Cancer Type:_____	____Heart disease Type:_____	____Seizures
____COPD	____High Blood Pressure	____Stroke
____Diabetes	____High Cholesterol	____Thyroid problems
____Eating disorder Type:_____	____Kidney/bladder problems	____Ulcers/colitis

Please describe any current or past medical treatment not listed above: _____

_____

Surgery or Hospital Stay Reason:	Dates of stay:	Hospital Admitted to:

Social History:

Please check (√) each that apply.

Marital status: _____Single _____Married _____Divorced _____Widowed

Tobacco use: _____Never _____Former _____Current Amount per day_____

Alcohol use: _____Never _____1-5 per week _____6-12 per week _____12 or more per week

Illegal street drugs: _____ Yes _____No If yes, please list: _____

Highest level of schooling completed:_____

Work status: _____Full time _____Part time _____Retired _____Student

_____Disabled _____Medical leave _____Homemaker _____Self-employed _____Other

Current occupation (if applicable): _____ Do you enjoy working? Yes No

How, if any, has your work experience been impacted by the presenting problem? _____

_____

Who do you live with (names, ages, and relationship to you)? _____

_____

_____

_____

Former Treatment:

Please review the following table and fill out the appropriate boxes with your information.

Type:	Yes or No	Approximate Dates	Reason
Residential Facility (In Patient stay)			
Intensive Out Patient program (IOP)			
Detox or Substance abuse facility			
Outpatient counseling services			

If you are not currently in counseling, would you like to attend counseling sessions? _____

In the past 24 hours, have you had any thoughts of hurting yourself or anyone else? _____