NIALife
CENTER FOR COUNSELING

Patient number: _____

Health History Form

Your answers on this form will help your psychiatrist (psychiatric medical doctor) better understand your medical concerns and conditions. If you cannot remember specific details, please do your best.

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL!

Name: _____ Date: _____

ALLERGIES:

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

	ALLERGY	**REACTION**
1.	_____	_____
2.	_____	_____

Preferred Pharmacy (Address/ Number):

_____

_____

Family Physician and/or Primary Health Care Provider:

Name: _____

Phone: _____

Address: _____

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May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

☐ Yes ☐ No

Signature: _____

Past Psychiatric History:

Diagnoses: _____

Medications: (past and present along with doses):

_____

_____

Suicide attempts:

☐ Yes ☐ No

Self-injury:

☐ Yes ☐ No

Psychiatric Hospitalizations (where and when):

_____

_____

Any psychotherapy (in addition to NIALife?):

☐ Yes ☐ No

Rehabilitation for substance abuse:

☐ Yes ☐ No

Family Psychiatric History:

Relative	Depression	Bipolar	Schizophrenia	Anxiety
Mom				
Dad				
Maternal Grandmother				
Maternal Grandfather				

Paternal Grandmother

Paternal Grandfather

Son

Daughter

Aunt

Uncle

Intellectual Disability:

☐ Yes ☐ No If yes, whom? _____

Substance Abuse:

☐ Yes ☐ No If yes, whom and which substance?

Any family member complete suicide? (who): _____

Your Past Medical History (Check all that apply):

☐ High blood pressure ☐ High cholesterol ☐ Asthma ☐ Diabetes
☐ Thyroid Problems ☐ Anemia ☐ Bleeding Disorder ☐ Seizures ☐ Stroke
☐ Heart Attack ☐ Cancer ☐ Kidney Disease ☐ Liver Disease Tuberculosis
☐ HIV/AIDS ☐ Weight loss surgery

Family Health History (Use above illnesses and list):

Mother: _____

Father: _____

Siblings: _____

Children: _____

LIST ALL MEDICATIONS YOU ARE TAKING (BOTH PRESCRIBED AND OVER THE COUNTER): _____

_____

_____

Has any family member suddenly died at a young age? (who): _____

☐ Yes ☐ No

Past Surgical History (list all Surgery, reasons, age):

1. _____

2. _____

3. _____

Substance Abuse History (You, the patient):

Alcohol (how many drinks per week): ____

☐ Yes ☐ No

Tobacco (Cigarettes, cigars, chew per day/week): ____

☐ Yes ☐ No

Drug use:

☐ Yes ☐ No (If yes, list drugs and how often? Last use?)

_____

Additional Health Information:

Please add any other information about your health that you would like the doctor to know:

_____

_____

_____

Patient Name (print): _____

Signature: _____

Parent Name/Signature (if under 18): _____