MENTAL HEALTH SUMMARY

Patient Name_____Occupation_____DOB_____
Address _____zip code_____
Home phone _____cell _____work_____
Emergency contact person _____Phone _____

Psychiatric History

Treatment history

Past Inpatient: no_____ yes_____ *(If yes, #_____ dates* _____
Past Outpatient: no____ yes_____ *(If yes, #_____ dates* _____
Substance Abuse Outpatient: no____ yes_____ *(If yes, #_____ dates*_____
Inpatient: no____ yes_____ *(If yes, #_____ dates* _____

Psychiatric Problems

Depression: no____ yes____ Suicidal: no___ yes___
In family: no____ yes____ (Relationship _____
Substance Abuse: no_____ yes_____ (Substances _____
_____
In family: no_____ yes_____ (Relationship _____
_____

Eating Disorder: no_____ yes_____

Abuse History (circle if appropriate)
Physical Sexual Emotional Neglect
Human Service Involvement *(circle)*
DSS DMH DYS Other_____

Pertinent Medical Problems, Conditions, Accidents

Condition or incident: _____ date_____
_____ date_____
_____ date_____
Medications _____
_____

Allergies to food or medication: no_____ yes_____ If yes, list _____
_____

Potential Health Hazards
cigarette smoker: no_____ yes_____
safe sex: no_____ yes_____