CONFIDENTIAL Psychiatric / Medical Information Provided by Family / Friend

Date:	
Submitted by:	
Relationship:	
Phone:	

Please note that this information was submitted by a family member or friend of the patiemt for informational purposes only.
This information is to remain confidential and not to be shared with the patient

Name *(Last, First, M.I.):*	**Date of Birth**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PSYCHIATRIC / MEDICAL HEALTH HISTORY

Psychiatric Diagnosis: Please check all diagnosis that apply

☐ Anxiety Disorder	☐ Depression	☐ Obsessive Compulsive Disorder	☐ Schizoaffective Disorder
☐ Bipolar Disorder	☐ Dual Diagnosis	☐ Panic Disorder	☐ Schizophrenia
☐ Borderline Personality Disorder	☐ Eating Disorder	☐ Post-Traumatic Stress Disorder	☐ Other (describe below)

Comments

Other Issues (dates; briefly describe)

☐ Suicide attempts

☐ Violence

☐ Alcohol Abuse

☐ Drug Abuse (List drugs)

☐ History of (or Potential for) Victimization by Other Patients

☐ History of Sexual Abuse or Trauma.

Other / Comments

List Other Medical Problems (E.G. Diabetes, High Blood Pressure, Heart Problems, Seizures Etc.)

Hospitalizations		
Year	Reason	Hospital

List Prescribed Drugs				
Name the Drug	Dosage	Frequency Taken	Time of Day to be Administered	Prescribing Pharmacy (Name and Location)

Allergies / Negative Reactions to Medications	
Name the Drug	Describe Reaction

Psychiatrist
Name:
Address:
Phone:

Physician
Name:
Address:
Phone:

Previous / Present Capabilities and Interests

Other Relevant Information