1500 W. 38th Street, Suite 53 · Austin, TX 78731
Austin Psychiatric Consultants
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AUSTIN PSYCHIATRIC CONSULTANTS

Psychological Assessment, Individual, Group, Couples, Family, & Play Therapy

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A division of Psychiatric Consultants of Ft. Worth, PA
Serving the mental health needs of Texans since 1979

PATIENT SOCIAL/MEDICAL HISTORY

Name _____ **Date** _____

Date of last physical exam: _____ **Name of primary care physician:** _____

List all current drugs/medications and who prescribed –include any supplements/amino acids:

_____ _____
_____ _____
_____ _____

List any known drug allergies/adverse drug reactions: _____

Current/past medical conditions & treating physicians:

_____ _____
_____ _____
_____ _____

Have you ever had a head injury? _____

How often do you use: tobacco: _____, drugs/alcohol: _____, other: _____

Academic: How far did you go in school?:_____ Future educational plans:_____

Problems you had in school (e/g., special education classes, tutor, learning disability, held back, etc.):

_____

_____

Employment: Current job:_____ How long held? _____

Previous job(s):_____

Have you had any problems with job instability? _____

Family of Origin: With whom did you live growing up?_____

Where did you grow up?:_____ How many siblings do you have?:_____

Any history of developmental delays _____

If your parents are divorced, how old were you when this occurred?:_____

How often do you speak to your family members?: _____

Was there any abuse (physical, emotional, sexual) in your family?:_____

_____

Any family history of mental illness, hospitalization, "nervous breakdown"?:_____

_____

Name _____

Please list names, ages, occupations, and level of education of family members:

NAME	AGE	RELATIONSHIP	LIVING/ DECEASED	IN HOUSE	OCCUPATION	EDUCATION

Did the following occur in your family?

____ Family frequently moved
____ Parent(s) unemployed for an extended period of time
____ Frequent, hostile arguing among family members
____ Death of parent(s) before you were 18
____ Parent(s) with a drinking/drug problem
____ Rape/sexual assault of yourself or family member
____ Family member attempted/committed suicide
____ Family member with an eating problem
____ Family member with debilitating illness or handicap
____ Family member prosecuted for criminal activity

Current Issue:

Please check any of the following items which concern you regarding current symptoms:

___ Self-esteem, self-confidence
___ Family conflicts or pressures
___ Anxiety, nervousness, fears
___ Friendship conflicts
___ Angry, hostile feelings
___ Loneliness
___ Traumatic experience
___ Depression
___ Relationship/marital concerns
___ Procrastination or motivation
___ Health problems
___ Gay/Lesbian issues
___ Eating or appetite problems
___ Suicidal feelings or behaviors
___ Alcohol or drug problems
___ Stress
___ Sexual concerns
___ Sleep problems
___ Parent-child problems
___ Work or career concerns
Other: _____
_____
_____

Additional Information regarding the main concern(s) that brought you here: _____
_____
_____

Name(s) of previous therapist(s)/dates seen: _____

Social Situation:

With whom do you live currently? For how long?:_____

Are you married? For how long?:_____

Do you have any children – please list ages, genders:_____

If you have had divorces, subsequent marriages, please list:_____

What are your hobbies?:_____

With whom do you spend your free time?:_____

Have you ever been in trouble with the authorities?: _____

How often/much do you drink alcohol?: _____

Do you use any other substances?:_____

Have you ever gotten in trouble due to drug/alcohol use?:_____

_____

Is there any family history of substance abuse?:_____