PATIENT HISTORY FORM

Desa & Associates, LLC

Psychiatric Holistic Health

319 Littleton Road, Suite 202, Westford, MA 01886

Phone : (978) 692-0096 **Email:** info@healingholistichealth.com

Patient Information

Patient Name: (First)_____ (Middle)_____(Last) _____

Date of Birth: _____

Reason for Visit

Reason for visit: _____

Psychiatric Diagnosis: _____

Medical Diagnosis: _____

Primary physical complaints: _____

Current Care

Are you currently under the care of another provider? Yes [ ] No [ ]

If yes, Doctor's name: _____ Specialty: _____

Reason for care: _____

Date of last visit: _____

Marital Status: S [ ] M [ ] D [ ] W [ ] Separated [ ]

Are you applying for disability? Yes [ ] No [ ] If yes, please explain: _____

Health History

Illness or Injury | Approx. Date | Complications/Comments | Full Recovery? Yes [ ] No [ ]

Surgery | Approx. Date | Complications/Comments | Full Recovery? Yes [ ] No [ ]

Family History

Cancer [ ] Diabetes [ ] Heart Problems [ ] Mental Illness [ ] Other: _____

Please explain: _____

Fatigue & Bowel Movements

What time(s) of the day are you most tired? _____

Bowel movements: >1/day [ ] 1/day [ ] Every 2 days [ ] 3/week [ ] 2/week [ ] Other: _____

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Current Medications/Supplements

Medications: _____

Dosage: _____

Purpose: _____

Side Effects: _____

Menstrual History

Date of last menstrual cycle: _____ Regular? Yes [ ] No [ ] If no, explain: _____

Cramping: Yes [ ] No [ ] Slight [ ] Moderate [ ] Severe [ ] Other: _____

PMS: Yes [ ] No [ ] Symptoms: Bloating [ ] Cravings [ ] Back Pain [ ] Moodiness [ ] Other: ___

Currently pregnant? Y / N Weeks: ___ Complications: _____

Birth Control: Ever used? Y / N Currently using? Y / N Total years: ___ Reason: _____

Appetite and Eating

Appetite: Excellent [ ] Good [ ] Fair [ ] Poor [ ]

Eating habits changed recently? Yes [ ] No [ ] If yes, describe: _____

Struggle with eating (e.g., binge/restrictive): _____

Following any diets/plans? _____

Ever treated for eating disorder? Y / N

Special diets: Diabetes [ ] Low fat [ ] Weight Loss [ ] Low Sodium [ ] Other: _____

Food allergies/sensitivities: _____

Substance Use

Smoker? Yes [ ] No [ ] If quit, when? _____ Quantity: <10/day [ ] 10-20/day [ ] >20/day [ ]

Alcohol: Daily [ ] Weekly [ ] Monthly [ ] Never [ ] Problematic to others? Yes [ ] No [ ]

Currently in recovery? Yes [ ] No [ ]

Illicit drug use? (specify): _____ History? Yes [ ] No [ ] In recovery? Yes [ ] No [ ]

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Physical Activity

Able to exercise? Yes [ ] No [ ] Frequency: _____

Activities you enjoy: _____

Symptom Profile

Circle relevant symptoms, list date of start and frequency.

Suicidality: Y/N Thoughts: Y/N Plan: Y/N Intent: Y/N Attempts: Y/N

Immediate needs (food, shelter, etc.): _____

Loss of interest: _____ Hopelessness: _____ Depression: _____

Sleep changes: _____ Appetite changes: _____

Self-harm: _____

Mood Swings, Anger, Anxiety, Racing Thoughts, etc. (describe): _____

Pain (neck, back, other): _____

Sleep issues: Falling [ ] Staying [ ] Nightmares [ ] Tired waking [ ]

Digestive/Allergy/Headache issues: _____

Memory, Dissociation, Flashbacks, Panic, Substance Use, Eating, Sexual, Relationships, etc.: _____

Mental/Emotional History

Describe your concerns: _____

Goals for medication: _____

Previous therapy: _____

Inpatient/residential history: _____

Current medications: _____

Past psychiatric meds: _____

Helpful meds and why: _____

Unhelpful meds and why: _____

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Patient & Family History

Family background: _____

Current family: _____

Significant relationships: _____

Support system: _____

Education: _____

Occupation: _____

Leisure interests: _____

Spiritual/Cultural: _____

Strengths: _____

Challenges: _____

Trauma History

Check all that apply and describe:

Physical assault [ ] Sexual assault [ ] Emotional abuse [ ] Neglect [ ] Domestic violence [ ]

Violent crime [ ] Other trauma: _____

How have these impacted you? _____

Additional Info

What else would you like us to know? _____

Certification:

I certify that the information provided is accurate to the best of my knowledge.

Printed Name (Patient/Guardian): _____ Date: _____

Signature (Patient/Guardian): _____ Date: _____