Transitions Center
Psychiatry & Addiction Medicine

New Patient - Clinical History

Name: _____ **DOB:** _____

ALLERGIES YES / NO If Yes, Details

_____

Reason for Seeking Consultation/Treatment:

_____

_____

_____

Current Psychiatric Medications YES / NO If Yes, Details

Drug Name: _____ Dose: _____

Drug Name: _____ Dose: _____

Drug Name: _____ Dose: _____

Drug Name: _____ Dose: _____

Non-Psychiatric Medications/Supplements/Vitamins

Drug Name: _____ Dose: _____

Drug Name: _____ Dose: _____

Drug Name: _____ Dose: _____

Drug Name: _____ Dose: _____

Psychiatric History/Previous Treatment YES / NO If Yes, Details

Prior Psychiatric Medications & Results: _____

_____

_____

_____

Psychiatric Hospitalization(s) _____

_____

Out-Patient Treatment (including psychotherapy/counseling) _____

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Past Suicide Attempts: _____

Medical History *(Major Surgeries, head injuries, seizures, chronic conditions, etc.)*

_____

_____

Alcohol Use YES / NO If Yes, Details

_____

Recreational/Illicit Drug Use YES / NO If Yes, Details

_____

Prescription Drug Overuse YES / NO If Yes, Details

_____

Treatment for Alcohol/Drug Abuse YES / NO If Yes, Details

_____

Family Psychiatric &/or Alcohol/Drug Abuse History YES / NO

If Yes, Details _____

_____

_____

_____

_____

Family Medical History _____

_____

_____

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Additional Information