Outpatient Services Admission Form

Name:_____Date of Birth: _____

Relationship Status: □ Married □ Single □ Divorced □ Widowed □ Engaged □ Separated □ In a relationship □ Polyamorous

Household composition – Living with:

Relationship	Name	Age

Occupation: _____

Length of time at position: _____

Combined household income (Monthly)-required to complete if you are applying for a sliding scale fee: _____

Financial Situation (Sources of income, history of bankruptcy, child support, etc.): _____

_____

Medications and Allergies Information:

Current Prescription Medications:

□ Not currently taking any prescription medications

Name of Medication	Dosage and Frequency	Reason	Who is prescribing?

Comments: _____

Pharmacy_____ Location: _____

Do you take any over the counter medications? □ Yes □ No
If yes, list : _____

Drug allergies or other allergies:

□ No known food or drug allergies

Type of Allergy (medication, food, environmental)	Reaction

Comments: _____

Current Primary Care Provider: _____

Date of last physical exam: _____

Medical Information:

Height:_____Weight: _____

Anemia (low blood count)	**Fainting spells/passing out**	**Lupus**
□ Present □ Past	□ Present □ Past	□ Present □ Past
Arthritis	**Glaucoma**	**Migraine headaches**
□ Present □ Past	□ Present □ Past	□ Present □ Past
Angina	**Head Injury/Accident**	**Multiple sclerosis**
□ Present □ Past	□ Present □ Past	□ Present □ Past
Asthma	**Heart disease**	**Obesity/overweight**
□ Present □ Past	□ Present □ Past	□ Present □ Past
Cancer	**High cholesterol**	**Seizures/convulsions**
□ Present □ Past	□ Present □ Past	□ Present □ Past
Chronic Bronchitis	**Hypertension (high blood pressure)**	**Strokes/TIA**
□ Present □ Past	□ Present □ Past	□ Present □ Past
COPD (emphysema)	**Hypotension (low blood pressure)**	**Thyroid disease**
□ Present □ Past	□ Present □ Past	□ Present □ Past
Diabetes	**Infectious diseases**	**Type of infectious disease (hepatitis, HIV, etc):**
□ Present □ Past	□ Present □ Past	
Digestive Problems	**Kidney disease**	**Tuberculosis**
□ Present □ Past	□ Present □ Past	□ Present □ Past
Eating Disorder	**Liver disease**	
□ Present □ Past	□ Present □ Past	

Other Medical conditions: _____

Hsve you had any surgeries and/or any problem pregnancies or deliveries? Yes_____No _____

If yes, please list and provide date(s):

_____

_____

Are you currently pregnant or planning a pregnancy? □ Yes □ No □ N/A

Do you have any speech, language or hearing problems? Yes_____No _____

If yes, please describe: _____

Are you currently experiencing any physical pain? Yes_____No _____

If yes, please describe the reason for pain, location, and duration:

_____

_____

If yes, describe intensity of pain on a scale of 1(lowest) to 10 (highest)

1_____2_____3_____4_____5_____6_____7_____8_____9_____10_____

Mental Health History:

Past mental health treatment:

□ No history of mental health diagnosis and/or treatment

Diagnosis	Length of time since diagnosed	Method of treatment	Length of treatment

Past psychiatric medications:

□ No history of taking psychiatric medications

Name of medication	Dose of medication	Date of medication	Effectiveness	Side effects

Past psychiatric hospitalizations:

□ No history of psychiatric hospitalizations

Date of psychiatric hospitalization	Where	Reason

Family History of Psychiatric, Substance Abuse, or Medical Issues:

□ No Family History of Psychiatric, Substance Abuse, or Medical issues

Family Member (relationship)	Psychiatric/Substance abuse/Medical Problem

Substance Abuse and Addiction History:

□ No History of Substance Abuse

Method/Use	Quantity	Frequency	Duration	Treatment History

Legal History:

□ No History of Legal Problems

Arrests: _____

Convictions: _____

Pending Legal Issues: _____

Driving Infractions: _____

Work History:

Job Held	Employer	Dates employed	Comments

Academic History:

Type of education (high school, college, etc.)	How far progressed?	Concerns/Performance

Developmental History and Milestones:

Birthplace: _____

Upbringing and milestones (where were you raised, parenting style, exposure to early adverse events, significant milestones?): _____

_____

Veteran Status: □ Yes □ No

If yes, type of discharge: _____

Hobbies and Interests: _____

Client: _____ Date: _____
(Parent or Guardian if Client is a Minor)

Clinician: _____ Date: _____

Reviewed: _____ Date: _____
Psychiatrist Signature