Behavioral Health of Cleveland
A SkyRidge Health Partner

Patient Contact Information

Patient Name _____
Date of Birth _____
Primary Care Physician _____
Referring Physician _____

Reason for Referral: _____
_____

Have you previously been under the care of a psychiatrist? Yes or No (If yes, please list):_____
_____

Are you currently seeing a therapist? Yes or No (If yes, please list name and contact #):
_____

Are you currently under the care of pain management? Yes or No (If yes, please list name and contact # for the treating physician): _____
_____

Do you use drugs? Yes or No (If yes, please list drug name(s), frequency of use and date of last use): _____
_____

Education/Employment History

Highest grade completed: _____
Are you currently a student? Yes or No (If yes, please list name of school and grade):
_____
Do you have a history of in/out of school suspension? Yes or No
Are you employed? Yes or No

Legal History

Do you have a history of legal trouble? Yes or No
Are you on probation? Yes or No

Social History

Who do you live with? _____
Please list behaviors of concern at home: _____
_____
Please list behaviors of concern at school: _____
_____
Please list behaviors of concern socially: _____
_____

Have you been treated for any of the following (please check all that apply)?

___Depression	___ADHD	___Bipolar (Manic/Depressive) D/O
___Anxiety	___OCD	___Schizophrenia
___Panic Attacks	___PTSD	___Alcohol/Drug Dependency
___Anorexia/Bulimia	___Binge-Eating	___ECT Treatment

___Other_____

Inpatient Psychiatric Treatment (please list all prior psychiatric hospitalizations (if any) below:

Date Length of Stay Name of Hospital Reason for Admission
_____
_____
_____

Have you ever attempted to harm/kill yourself? If so, please list below:

Approximate date of attempt How did you attempt (method)?
_____
_____
_____

Please list ALL current medications:

Name of Medication Dosage Side Effects (if any) Prescribing Physician
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list ALL previous psychotropic medications:

Name of Medication Dosage Side Effects Reason for Discontinuing Use

_____

_____

_____

Medical History (please check all that apply)

___High Blood Pressure	___GI Problems	___Cancer
___Lung Disease	___Arthritis	___Genital Problems
___Diabetes	___Hepatitis/Liver Damage	___Eating D/O
___Heart Disease	___Endocrine/Hormone Problems	___Eye Problems
___Thyroid Disease	___Neurological Problems	___Chronic Pain
___Anemia	___HIV/AIDS	___Head Injury
___Asthma	___UTI/Kidney Problems	___Fibromyalgia
___Skin Disease	___Migraines/Headaches	___Lupus
___Seizures	___Ear/Nose/Throat Problems	___Sleep Apnea
___High Cholesterol	___Gynecological Problems/Hysterectomy	

___Other Medical Issues (please list) _____

List all prior surgeries and hospitalizations for medical illnesses: _____

_____

Are you allergic to any medication or food? If so, please list below:

_____

Family Psychiatric History

	Father	Mother	Aunt	Uncle	Siblings	Children	Other
Depression							
Anxiety							
Panic Attacks							
PTSD							
Bipolar D/O							
Schizophrenia							
Alcohol/Drug Dependency							
ADHD							
Suicide Attempts/Completion							
Inpatient Psychiatric Care							
Other							