MINDFUL WELLNESS CENTER, PLLC

PATIENT HISTORY

NAME_____ ***DATE***_____

PLEASE TAKE YOUR TIME AND COMPLETE THE ENTIRE FORM. You may use the back if needed for more explanation.

Identifying Information:

Date of Birth: _____ Age: _____ Sex: _____ Place of Birth: _____

Religion: _____ Ethnicity: _____ Driver's License Number: _____

Occupation: _____ Employer: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Cell Phone: _____ Emergency Contact's Home Phone: _____

Reason for present visit (Describe in your own words):

_____

_____

_____

Referred by: _____

How are your problems affecting your daily life? _____

_____

DEMOGRAPHICS

Marital Status ❒ Never Married ❒ Married ❒ Divorced ❒ Cohabiting ❒ Widowed ❒ Separated

Anyone else living with you? _____

FAMILY HISTORY

Please list any family stressors _____

_____

DO YOU HAVE A FAMILY HISTORY OF:

1) Mental illness or substance abuse ❒ No ❒ Yes Explain: _____

2) Suicide or homicidal ideation or, attempt ❒ No ❒ Yes Explain: _____

SYMPTOMS *Please check off symptoms you are currently experiencing. Please explain where indicated.*

❑ Depression/feel sad or blue _____

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- ❑ Decreased self-care _____
- ❑ Crying spells _____
- ❑ Decreased activity/ everything is an effort _____
- ❑ Fear of dying _____
- ❑ Mood swings _____
- ❑ Racing thoughts _____
- ❑ Loneliness _____
- ❑ Emptiness/hopeless _____
- ❑ Increase in appetite _____
- ❑ Loss of appetite _____
- ❑ Guilt/shame _____
- ❑ Sexual problems _____
- ❑ Isolation _____
- ❑ Not seeing friends _____
- ❑ Too much / too little sleep _____
- ❑ Nightmares _____
- ❑ Poor concentration _____
- ❑ Nervous/anxious _____
- ❑ Job stress _____
- ❑ Financial worries _____
- ❑ Relationship breakup _____
- ❑ Relationship problems _____
- ❑ Panic attacks _____
- ❑ Increased alcohol use _____
- ❑ Blackouts _____
- ❑ Increased drug use _____
- ❑ Withdrawal symptoms _____
- ❑ Feeling controlled _____
- ❑ Hearing voices _____
- ❑ Feeling talked about _____
- ❑ Seeing things others don't _____
- ❑ Unusual thoughts _____
- ❑ Confusion _____
- ❑ Other_____

_____

SUBSTANCE USE

Have you ever had any problems from substance use/abuse? ❒ Yes ❒ No

(If yes, please describe) _____

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Ever been treated for substance abuse, substance dependence, or possible (accidental) overdose? ❒ Yes ❒ No

Inpatient treatment program ❒ No ❒ Yes When_____ Where_____
Intensive outpatient program ❒ No ❒ Yes When_____ Where_____
Outpatient program ❒ No ❒ Yes When_____ Where_____

MENTAL HEALTH TREATMENT

Outpatient? ❒ No ❒ Yes When_____ Where_____
Details of treatment: _____

_____

Inpatient? ❒ No ❒ Yes When_____ Where_____
Details of treatment: _____

_____

Day Treatment? ❒ No ❒ Yes When_____ Where_____

Other treatment experiences _____

HARM ASSESSMENT

- Have you ever made or threatened to carry out a suicide attempt? ❒ Yes ❒ No

(If yes, explain in detail) _____

_____

- Have you harmed or threatened to harm another person? ❒ Yes ❒ No

(If yes, explain in detail) _____

_____

- Other self-harm behaviors _____ ❒ Yes ❒ No

(If yes, explain)_____

Has any family member attempted or committed suicide? ❒ Yes ❒ No If yes, who_____

Details: _____

EMPLOYMENT

Did your employer refer you for help? ❒ Yes ❒ No

Occupation _____ Employer _____

Are you experiencing problems at work/school? ❒ No ❒ Yes Describe_____

FINANCIAL

Are you currently experiencing any financial concerns? ❒ No ❒ Yes Describe_____

LEGAL

Any past or present litigation or legal problems? ❒ Yes ❒ No
(If yes, explain) _____

_____

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Court Dates Pending? ❒ No ❒ **Yes** Describe_____
Pending Lawsuits? ❒ No ❒ Yes Describe_____

MILITARY ❒ No ❒ Yes Type of Discharge_____
Branch _____ Dates of service_____
Combat experience? ❒ No ❒ Yes Describe_____
Are you troubled by your experiences? ❒ No ❒ Yes Describe_____

EDUCATION

Last grade completed_____ Degree_____ Are you in school now? ❒ Yes ❒ No
Did you ever receive special services at school? ❒ No ❒ Yes Describe _____
Have you ever been identified as having learning problems ❒ No ❒ Yes Describe _____

MEDICAL

Primary Care Physician_____ Phone_____ Fax_____
Address _____

I hereby ❒ authorize / ❒ do not authorize Mindful Wellness Center to exchange information regarding my mental health/ substance abuse treatment and medical healthcare for continuity of care purposes as may be necessary. I understand that I may revoke this authorization at any time by written notice to Mindful Wellness Center. It is my responsibility to provide notification if I choose to change my Primary Care Physician.

Patient Signature_____ DATE_____

Date of last annual physical exam: _____

In general would you say your health is ❒ Excellent ❒ Very Good ❒ Good ❒ Fair ❒ Poor

Please indicate if you have serious or chronic medical or surgical conditions: _____
_____
_____

FOR WOMEN ONLY

Number of births_____ Abortions _____ Miscarriages_____ Still births _____
Do you have PMS? ❒ Yes ❒ No Are you pregnant? ❒ Yes ❒ No Are you Menopausal? ❒ Yes ❒ No
List other medical concerns: _____

Patient Signature_____ DATE_____

MEDICATION INFORMATION

Please list prescribed and other over the counter medications that you are currently taking:

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Medication Name	Prescribed by	Dose	Date Started	Reason

Patient Signature_____ DATE_____