MINDPATH
HEALTH

Patient Health Screen - Adult

☐ **I would prefer to speak with my provider before completing this form (signature required)**

Patient Information:

Last Name: ____________________________ First Name: ____________________________ Date of Birth: __________

Emergency Contact:

Name: ___________________________________ Relationship: _______________________ Phone Number: __________

1. Please state the reason for making this appointment:
____
____

2. Have you ever been diagnosed with any psychiatric conditions? ☐ Yes ☐ No
____
____

3. Please list all current prescription medications, over the counter medications and/or supplements you are taking:

Medication	Dosage	Taking for how long?	Med helpful? / Concerns

4. Please list past medications that you discontinued and for what reason:

Medication	Dosage	Taking for how long?	Med helpful? / Concerns

5. Please list any allergies to medications:
____

6. Please list any current medical problems:
____
____

7. Please list any major surgeries:
____
____

8. Please tell us about your current/past providers:

Do you have a primary care provider?	Have you ever seen a psychiatrist before?	Are you currently seeing a therapist?
☐ Yes ☐ No Dr. Name: Dr. Phone #: Dr. Location: Last visit date:	☐ Yes ☐ No Dr. Name: Dr. Phone #: Dr. Location: Last visit date:	☐ Yes ☐ No Dr. Name: Dr. Phone #: Dr. Location: Last visit date:

9. Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

Hospital Name	City	Admit Date	Discharge Date	Reason for Hospitalization

10. Is there a family history of psychiatric conditions? ☐ Yes ☐ No
If yes, please list the psychiatric condition(s) and your relationship:
____
____

11. Please list your use of:

	Never	Once or Twice	Monthly	Weekly	Daily
Alcohol (for men, 5 or more drinks a day; for women, 4 or more drinks a day)	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐
Prescription Drugs for non-medical reasons	☐	☐	☐	☐	☐
Illegal drugs	☐	☐	☐	☐	☐

12. Please tell us more about yourself:

Education Level:	Employment:	Relationship:	Do you have children?
❑ Less than high school ❑ High School ❑ AA / AS ❑ Bachelors ❑ Masters ❑ Post Grad	❑ Employed ❑ Unemployed ❑ Student ❑ Stay at home parent ❑ Disabled	❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ Yes ❑ No If yes, how many? ________

13. Please list everyone who currently lives with you:
____

14. Are you currently dealing with significant financial problems (bankruptcy, foreclosure, large debt, etc.)? ☐ Yes ☐ No
If yes, please list below:
____

15. Are you currently dealing with significant legal problems (custody issues, divorce, DUIs, etc.)? ☐ Yes ☐ No
If yes, please list below:
____

16. Please list any other information you think is important for the provider to know:
____
____

____ _______________________
Name of Patient Today's Date

____
Patient's Signature