



Co-Morbidities	
Psychosis: <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other <input type="checkbox"/> None	Anxiety: <input type="checkbox"/> Panic <input type="checkbox"/> Phobia <input type="checkbox"/> Generalized <input type="checkbox"/> OCD <input type="checkbox"/> Social Phobia <input type="checkbox"/> PTSD
OC Spectrum: <input type="checkbox"/> Tourette Syndrome <input type="checkbox"/> Body Dysmorphic Disorder <input type="checkbox"/> Trichotillomania <input type="checkbox"/> ADHD <input type="checkbox"/> Other:	Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No ETOH/Substance Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ever <input type="checkbox"/> Currently If you ever or currently abused, what and when? Personality Disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe:
Past Psychiatric/Medical History	
Number of Psych hospitalizations:	Ever Been Legally committed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Suicide Attempts: <input type="checkbox"/> Yes <input type="checkbox"/> No How many? Methods:	Dates of psychiatric hospitalizations:
Additional Medical History:	
Allergies:	



Surgical History:

Social History:

Single Married Divorced Children Lives with:

Occupation:

Hobbies:

Guns in the home: Yes No

History of legal problems:

Tobacco: Yes No. If yes, how many packs? _____ How many years? _____

Alcohol: Yes No. If yes, how much (glasses, cans, shots)? _____ Type? _____

Illicit Drugs: Yes No. If yes, what? _____

Caregiver/Social Issues:

Family Medical History:

Family History of Psychiatric Disorders:



Other Augmenting Agents	Total Duration	Maximum Dose	Maximum Dose Duration	Dates

Referring Psychiatrist Signature

Printed Name

Date