

Name: _____ DOB _____ Age _____

Referring Provider: _____ Phone _____

Primary Care Provider: _____ Phone _____

Mental Health Providers: _____ Phone _____

ALLERGIES

Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY

Do you have any of these conditions? Check appropriate box and provide date of onset

= Past Condition = Current Condition

NEUROLOGIC / MOOD

- Depression _____
- Anxiety _____
- PTSD _____
- Insomnia _____
- Schizophrenia _____
- Hallucinations _____
- ADD/ADHD _____
- Suicidal _____

- History of Mental Health Crises _____

- Seizures _____
- Stroke _____
- Neuromuscular Disease _____
- History of Psychiatric Admission _____

- Other _____

METABOLIC / ENDOCRINE

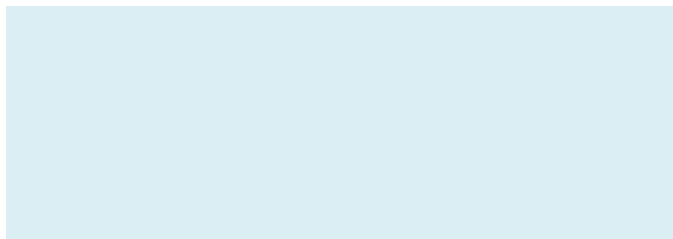
- Hypothyroid (underactive) _____
- Hyperthyroidism (overactive thyroid) _____
- Other _____

RESPIRATORY

- Shortness of Breath _____
- Asthma _____
- Obstructive Sleep Apnea _____
- Pulmonary Hypertension _____
- Other Lung Disorders _____

GU /GI

- Kidney Disease _____
- Liver Disease _____
- Other _____



Name: _____ DOB _____ Date _____

CARDIOVASCULAR

- High Blood Pressure
Controlled / Uncontrolled _____
- Chest Pain _____
- Heart Murmur _____
- Heart Attack _____
- Valve Disease _____
- Heart Failure _____
- Abnormal Heart Rhythm _____
- Bleeding Disorder _____
- Other _____

PAIN

- Acute Pain _____
- Chronic Pain _____
- Fibromyalgia _____
- Other _____

INFECTIOUS

- HIV _____
- Tuberculosis _____
- Hepatitis _____
- Other _____

HEMATOLOGY / ONCOLOGY

- Bleeding Disorder _____
- Cancer (explain) _____
- Other _____

OTHER

- Substance Abuse (please circle)
 Marijuana Cocaine Methamphetamine
 Heroin Ketamine
- Other Recreational drugs _____
- Last Use _____
- History of assault _____
- History of violent behavior _____
- Other _____

PAST SURGICAL HISTORY None

Name: _____ DOB _____ Date _____

CURRENT MEDICATIONS / SUPPLEMENTS None

NAME / DOSE	Reason For Use

I am currently compliant with all medications prescribed by my primary care and/or mental health provider:

Yes No **If no, please explain:** _____

Patient Signature _____ Date _____ Time _____