



DrJohnCantwell.com

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Adult History Form

Please print and accurately complete every blank on this form.

Patient Name: _____ Date of Birth ___/___/___

Appointment Date _____

Why are you coming to see Dr. Cantwell today and how do you hope he can help you?

Additional Blank Sheet of Paper – CIRCLE ARROW→

Medication Allergies: _____ →

Current Psychiatric Medications: Name/Dose/Directions/Benefit/Side Effects:

_____ →

Current Other Medications: Name/Dose/Directions/Condition Treated:

_____ →

Current Counselor: Name _____ Phone Number _____

Appointment Frequency _____ How long seen? _____

Primary Care Provider: Name _____ Phone Number _____

Other Medical Providers Name/Number: _____

_____ →

COMPLETE & SIGN A SEPARATE RELEASE OF INFORMATION/MEDICAL RECORD REQUEST FOR ALL

PSYCHIATRIC HISTORY:

Previous psychiatrist name(s), when & how long seen? _____
_____ →

Past counselor name(s), when & how long seen? _____
_____ →

Prior Psychiatric Hospitalizations or Substance Rehabilitation: Yes ___ No ___
Where, when & how long? _____
_____ →

Suicide Attempts: Yes ___ No ___ How many times? ___ When was the first? _____
When was last? _____ How did you attempt? _____
Other Self Harm: Yes ___ No ___ How many times? ___ When was the first? _____
When was last? _____ How did you harm yourself? _____
Psychiatric Diagnoses: _____

Abuse History: Physical ___ Sexual ___ Emotional ___ (Describe When, What & By Whom)

_____ →

SUBSTANCE USE HISTORY:

Tobacco: Yes ___ No ___, How much/how often? _____
Caffeine: Yes ___ No ___ How many per day? _____ What is your cut off time? _____
Alcohol: Yes ___ No ___ How much/how often? _____

Drugs, including but not limited to marijuana, cocaine, crack, ecstasy, LSD, mushrooms,
meth/amphetamines, opiates, benzodiazepines, inhalants, etc.):
List any recreational drugs you've taken, how often you take them, and when was last time?

_____ →

Past Psychiatric Medications: Name/Maximum Dose/Benefits/Side Effects/How Long Taken

_____ →

CHECK ALL SYMPTOMS THAT APPLY TO YOU IN THE PAST SEVERAL WEEKS TO MONTHS:

Depression: Sad ____, Hopeless ____, Helpless ____, Worthless ____, Guilt ____, Crying ____, Indecisive ____, Irritability ____, Social Isolation ____, Loss of Motivation ____, Loss of memory/concentration ____, Loss of interest/pleasure ____, Decreased sex drive ____, Pessimism ____, Wishing You were Dead ____, Thoughts of Killing Yourself ____, Thoughts of Hurting Yourself ____, What specifically have you thought about doing to kill or hurt yourself? _____

When is the *last time* and *how* did you try to hurt or kill yourself? _____

Who did you tell and *what medical treatment* did you seek for it? _____

Do you regret failing and why? _____

Mania: Elevated or Euphoric Mood ____, Rage ____, Excessive/Fast Talking ____, Racing Thoughts ____, Increased Energy ____, Increased Activity ____, Impulsivity ____, Grandiose Thinking ____, Increased Sex Drive ____, Spending Sprees ____, Risk Taking ____, Recklessness ____, Invincible ____, **Anxiety:** Nervous ____, Excessive Worry ____, Ruminating ____, Muscle tension ____, Avoidant ____, Overwhelmed ____, Panic ____, Feeling of Doom/Terror ____, Tremor ____, Shortness of Breath ____, Chest Discomfort ____, Heart Pounding ____, Numbness/Tingling ____, Nervous stomach ____, Obsessing about weight gain ____, Nightmares ____, Intrusive Thoughts ____, Increased Startle ____, Flashbacks of Traumatic Events ____, Germ Phobia ____, Excessive Hand Washing ____, Excessive Orderliness ____, Excessive Cleaning ____, Perfectionistic ____, Compulsive Behaviors/Rituals (Describe) _____

Fears of: Leaving Home ____, Being Alone ____, Meeting People ____, Crowds ____, Open Spaces ____, Fear of Driving ____, Specific Situations/Things (Describe) _____

ADHD: Problems Paying Attention ____, Distractibility ____, Hyperactivity ____, Impulsivity ____, _____

Psychosis: Auditory Hallucinations ____, Visual Hallucinations ____, Others Are Out to Get You ____, Impaired Reality Testing ____, Things Happen That Usually Refer to You ____, Someone or Something Outside Controls Your Thinking (Describe) _____

MEDICAL REVIEW OF SYMPTOMS: Fever ____, Chills ____, Sweats ____, Rash ____, Seizures ____, Dizziness ____, Fainting Spells ____, Head Trauma w/ or w/out (circle) loss consciousness ____, Headaches (Describe, Including Frequency, Duration) _____ →

Loss of Balance ____, Problems Falling ____, Numbness ____, Extremity Weakness ____, Anemia ____, Loss of Vision ____, Blurred/Double (circle) Vision ____, Eye/Ear (circle) Pain ____, Glaucoma ____, Ringing in Ears ____, Hearing Loss ____, Hair loss ____, Heat/Cold (Circle) Intolerance ____, Thyroid Problem (circle High or Low) ____, Increased Thirst ____, Urinary frequency ____, Blood Sugar High/Low (Circle) ____, Diabetes ____, Chest Pain ____, Palpitations ____, Calf/leg pain ____, Swelling ____, Heart Disease ____, High Blood Pressure ____, Short of Breath ____, Wheezing ____, Coughing ____, Asthma ____, Allergies ____, COPD ____, Coughing up blood ____, Abdominal Pain ____, Swallowing Problems ____, Nausea ____, Vomiting ____, Throwing up blood ____, Blood in stool ____, Heartburn/Reflux ____, Constipation ____, Diarrhea ____, Urinary Pain ____, Urinary Urgency ____, Urinary Blood ____, PMS ____, Menses Regular/Irregular (Circle) ____, **Breastfeeding** __ until ____, _____

Pregnant _____ (Due Date _____), **LAST MENSTRUAL PERIOD** _____,

Chronic Pain (Describe): _____ →