PRIORITY PSYCHIATRY

95 Vernon Street, Suite 302
Worcester, MA 01610

History

Name:

FAMILY INFORMATION:

	Age	living with you?	Psychiatric Illnesses
Mother :			
Father :			
Siblings :			

Children :

Spouse/ partner:

Ex-partners:
Other relatives :

EDUCATION:
Current schooling or Degree(s) highest grade/degrees

Describe any learning problems in school:

Describe any behavioral or hyperactivity problems in school:

RECENT WORK HISTORY:

MEDICAL HISTORY
Current medical conditions:

Previously diagnosed medical conditions and surgeries:

Any history of seizures, loss of consciousness, or head injury?
Allergies (indicate what sort of reaction to each medication):

Medications you are currently taking, including dose and frequency:

Psychiatric medications you have taken in the past (indicate duration and effect):

Describe your use of each substance in the past and present
Alcohol:

Opioids:

Cocaine:

Marijuana:
Caffeinated beverages:
Nicotine Smoking:
Other Drugs:

PRIOR PSYCHIATRIC TREATMENT
Please describe any prior psychiatric treatment with psychiatrists and hospitalizations:

Describe any experiences, trauma, or losses in your life that have been difficult for you

Why are you seeking help at this time? What are your goals for treatment?