Living Well Behavioral Health, Inc.

Personal History Form

Patient Name: _____
(Please Print) First Middle Last

Reason for your visit: _____

Have you ever seen a psychiatrist or counselor before? _____

If yes, please list their names: _____

Please list all medications that you are taking: _____

_____

Do you or have you ever had a problem with drugs or alcohol? _____

Have you ever been in a treatment facility for substance abuse? _____

If yes, please list the name of the facility and dates of treatment: _____

_____

Has anyone in your family been treated for emotional or substance abuse problems? _____

If yes, who? _____

Do you have any current medical problems? _____

If yes, please describe: _____

_____

Have you ever been hospitalized? _____

If yes, please describe: _____

_____

Please list any allergies to medications, if any: _____

_____

If patient is a student, please list the name of the school and grade level: _____

_____

Whom do you live with? Please list his/her name, age, and relationship to the patient: _____

_____