



**ADULT INTAKE FORM**

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
First Last  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender \_\_\_\_\_ Race \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street City State Zip  
 Phone number(s): \_\_\_\_\_  
Home Cell Work  
 E-mail address: \_\_\_\_\_

**REFERRAL INFORMATION**

Who referred you to this practice? Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PRESENTING PROBLEM**

What is the **PROBLEM** for which you are seeking assistance? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 When did you first notice this problem? \_\_\_\_\_  
 What caused you to seek treatment at this time? \_\_\_\_\_  
 \_\_\_\_\_  
 How has this problem affected your **ABILITY TO FUNCTION**? At home: \_\_\_\_\_  
 \_\_\_\_\_  
 At school/work: \_\_\_\_\_  
 \_\_\_\_\_  
 In your community: \_\_\_\_\_  
 \_\_\_\_\_

What are the **LIFE STRESSORS** that contribute to this problem? \_\_\_\_\_

What are **SPECIFIC GOALS** you want to accomplish by being in treatment? How do you want your life to be different? \_\_\_\_\_

**SYMPTOM CHECKLISTS: Please indicate if you have experienced any of the following in the past two weeks. CIRCLE THE ITEM IF IT HAS BEEN LONG-STANDING OR SEEMS TO BE PART OF YOUR PERSONALITY.**

**DEPRESSION**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Sadness                   | <input type="checkbox"/> Self-criticism/Blame     | <input type="checkbox"/> Loss of Energy/Fatigue   |
| <input type="checkbox"/> Hopeless/Discouraged      | <input type="checkbox"/> Hurting Yourself/Want to | <input type="checkbox"/> Sleep Problems _____     |
| <input type="checkbox"/> Feelings of Failure       | <input type="checkbox"/> Suicidal Thoughts/wishes | <input type="checkbox"/> Irritability             |
| <input type="checkbox"/> Feeling Helpless          | <input type="checkbox"/> Crying                   | <input type="checkbox"/> Appetite Change +/-      |
| <input type="checkbox"/> Loss of Pleasure/Interest | <input type="checkbox"/> Agitation / Restlessness | <input type="checkbox"/> Weight Gain/Loss __lbs.  |
| <input type="checkbox"/> Feelings of Guilt         | <input type="checkbox"/> Social Withdrawal        | <input type="checkbox"/> Concentration Difficulty |
| <input type="checkbox"/> Feeling Punished          | <input type="checkbox"/> Indecisiveness           | <input type="checkbox"/> Poor Memory              |
| <input type="checkbox"/> Loss of Confidence        | <input type="checkbox"/> Feeling Worthless        | <input type="checkbox"/> Loss of Interest in Sex  |

**BIPOLAR DISORDER**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Mood Swings              | <input type="checkbox"/> High Level of Energy | <input type="checkbox"/> Irritable/Argumentative |
| <input type="checkbox"/> Feeling "High" w/o drugs | <input type="checkbox"/> Unusually Active     | <input type="checkbox"/> Jumpy/Can't Relax       |
| <input type="checkbox"/> Elevated Self-Confidence | <input type="checkbox"/> Unusually Productive | <input type="checkbox"/> Excessive Spending      |
| <input type="checkbox"/> More Outgoing/ Sociable  | <input type="checkbox"/> Can't Focus on Tasks | <input type="checkbox"/> Inapp. Sexual Behaviors |
| <input type="checkbox"/> Talking More or Faster   | <input type="checkbox"/> Racing Thoughts      | <input type="checkbox"/> Other Risky Behaviors   |
| <input type="checkbox"/> Little Need for Sleep    | <input type="checkbox"/> Can't Shut Mind Off  |  |

**POSTTRAUMATIC STRESS DISORDER**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Traumatic Memories        | <input type="checkbox"/> Avoids Reminders    | <input type="checkbox"/> Emotional Numbness   |
| <input type="checkbox"/> Distressed at Reminders   | <input type="checkbox"/> Frequent Nightmares | <input type="checkbox"/> Can't Remember Event |
| <input type="checkbox"/> Easily Startled / Aroused | <input type="checkbox"/> Flashbacks          |   |

**ANXIETY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Constant Worrying        | <input type="checkbox"/> Hands Trembling        | <input type="checkbox"/> Unable to Relax         |
| <input type="checkbox"/> Fear of the Worst        | <input type="checkbox"/> Shaky                  | <input type="checkbox"/> Muscle Tension          |
| <input type="checkbox"/> Scared/Terrified         | <input type="checkbox"/> Numbness/Tingling      | <input type="checkbox"/> Dizzy/Lightheaded/Faint |
| <input type="checkbox"/> Feeling Hot/Face Flushed | <input type="checkbox"/> Nervous/Jittery        | <input type="checkbox"/> Heart Pounding/Racing   |
| <input type="checkbox"/> Sweating w/o Heat        | <input type="checkbox"/> Fear of Losing Control | <input type="checkbox"/> Feelings of Choking     |
| <input type="checkbox"/> Wobbliness in Legs       | <input type="checkbox"/> Fear of Going Crazy    | <input type="checkbox"/> Difficulty Breathing    |
| <input type="checkbox"/> Unsteady                 | <input type="checkbox"/> Fear of Dying          | <input type="checkbox"/> Abdominal Discomfort    |

**SOCIAL ANXIETY**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Shy/Timid       | <input type="checkbox"/> Avoiding Public Places | <input type="checkbox"/> Dislike Attention on You |
| <input type="checkbox"/> Avoiding Crowds | <input type="checkbox"/> Self-conscious         | <input type="checkbox"/> Feeling Judged by Others |

**OBSESSIVE COMPULSIVE DISORDER**

- |  |  |
|--|--|
| <input type="checkbox"/> Obsessive Thoughts      | <input type="checkbox"/> Compulsive Counting   |
| <input type="checkbox"/> Repetitive Thoughts     | <input type="checkbox"/> Compulsive “Checking” |
| <input type="checkbox"/> Compulsive Hand Washing | <input type="checkbox"/> Compulsive Neatness   |

**ATTENTION/HYPERACTIVITY PROBLEMS**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Distractible          | <input type="checkbox"/> Impulsive        | <input type="checkbox"/> Indecisive        |
| <input type="checkbox"/> Poor Concentration    | <input type="checkbox"/> Procrastinates   | <input type="checkbox"/> Can’t Sit Still   |
| <input type="checkbox"/> Many Unfinished Tasks | <input type="checkbox"/> Forgetful        | <input type="checkbox"/> Leaves Seat       |
| <input type="checkbox"/> Hyperactive           | <input type="checkbox"/> Misplaces Things | <input type="checkbox"/> Interrupts Others |

**BEHAVIORAL PROBLEMS**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Physical Aggression   | <input type="checkbox"/> Destroying Property | <input type="checkbox"/> Fire Setting    |
| <input type="checkbox"/> Extreme Anger or Rage | <input type="checkbox"/> Throwing Things     | <input type="checkbox"/> Hurting Animals |
| <input type="checkbox"/> Verbal Altercations   |  |  |

**EATING DISORDERS**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Fear of Weight Gain | <input type="checkbox"/> Distorted Body Image | <input type="checkbox"/> Excessive Dieting    |
| <input type="checkbox"/> Binging/Purging     | <input type="checkbox"/> Excessive Exercising | <input type="checkbox"/> Excessive Overeating |

**DISSOCIATION**

- |  |  |
|--|--|
| <input type="checkbox"/> Feeling Outside Your Body | <input type="checkbox"/> Time Elapsed, No Memory |
| <input type="checkbox"/> Things Feel “Not Real”    | <input type="checkbox"/> Gaps in Knowledge       |

**PSYCHOSIS**

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Hearing Voices Others Don’t | <input type="checkbox"/> Paranoia  |
| <input type="checkbox"/> Seeing Things Others Don’t  | <input type="checkbox"/> Delusions |

**AUTISM SPECTRUM DISORDER**

- |   |   |
|---|---|
| <input type="checkbox"/> Socially Unconnected/Awkward | <input type="checkbox"/> Rigidity/Inflexibility             |
| <input type="checkbox"/> Avoids Eye Contact           | <input type="checkbox"/> Unusual Repetitive Behaviors       |
| <input type="checkbox"/> Language Impairments         | <input type="checkbox"/> Intense Preoccupation with Subject |

## MENTAL HEALTH HISTORY

Have you recently experienced a **SIGNIFICANT LOSS**? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Have you ever been the **VICTIM OF ABUSE** (Physical, Emotional, Mental, Verbal or Sexual)? \_\_\_\_\_

Or the **VICTIM OF DOMESTIC VIOLENCE**? \_\_\_\_\_ Or the **VICTIM OF NEGLECT** (Emotional or Physical)? \_\_\_\_\_ If yes, please circle all that apply and explain (if you are comfortable doing so): \_\_\_\_\_

Have you ever been a **WITNESS OF VIOLENCE, ABUSE OR NEGLECT**? \_\_\_\_\_ If yes, please explain. \_\_\_\_\_

Have you ever been the **PERPETRATOR OF VIOLENCE, ABUSE OR NEGLECT**? \_\_\_\_\_ If yes, please explain. \_\_\_\_\_

Have you ever **HARMED YOURSELF INTENTIONALLY**? \_\_\_\_\_ **ATTEMPTED SUICIDE**? \_\_\_\_\_ If yes, please explain. \_\_\_\_\_

**MENTAL HEALTH DIAGNOSES:** please REVIEW THE LIST BELOW and consider yourself, your immediate family, and all of your relatives on both sides of your family. (Maternal is your mother's side of the family and Paternal is your father's side of the family.) Include parents, brothers, sisters, aunts, uncles, grandparents, and first cousins.

IF YOU (OR A RELATIVE) HAVE BEEN DIAGNOSED WITH ANY OF THESE DISORDERS, CHECK THE APPROPRIATE BOX (ES). If a relative, describe his/her relation to you (such as maternal grandfather) and his/her treatment history (if applicable). *We ask for your treatment history elsewhere.*

You    Relative

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | ADD/ADHD _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism / Asperger's / Pervasive Developmental Disorder _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Learning disabilities _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental retardation/Intellectual Disability _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Speech or Language Disorder _____                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol/Drug Dependence/Abuse _____                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Anger Problems/Intermittent Explosive Disorder _____                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety (Chronic Worrying) _____                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Body-Focused Repetitive Behaviors (Skin Picking, Hair Pulling) _____ |

You Relative

- OCD (Obsessive Compulsive Disorder) \_\_\_\_\_
- Panic Disorder \_\_\_\_\_
- Phobias \_\_\_\_\_
- Social Anxiety \_\_\_\_\_
- Depression/Dysthymia \_\_\_\_\_
- Bipolar Disorder (Manic Depression) \_\_\_\_\_
- PTSD (Post Traumatic Stress Disorder) \_\_\_\_\_
- Self harm/Self-mutilation \_\_\_\_\_
- Suicide, Attempted/Completed \_\_\_\_\_
- Eating Disorders \_\_\_\_\_
- Nervous breakdown \_\_\_\_\_
- Schizophrenia or Other Psychosis \_\_\_\_\_
- Seizures or Other Neurological Disorder \_\_\_\_\_
- Other \_\_\_\_\_

**OUTPATIENT TREATMENT:** Are you now receiving treatment, or have you received treatment in the past, for any of the problems above? \_\_\_\_\_ If yes, please give information below:

Name	Location	When	For how long?	Problem/Diagnosis
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Therapist: \_\_\_\_\_

\_\_\_\_\_

Psychiatrist: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PSYCHIATRIC HOSPITALIZATION OR INTENSIVE DAY TREATMENT PROGRAM:**

Where	When (month/year)	Type and Length of Stay	Diagnosis	Was it Productive?
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CURRENT PSYCHIATRIC MEDICATION:**

Name	Dosage	When Prescribed	Who Prescribed	Response
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you take your medication as prescribed? \_\_\_\_\_ If not, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PREVIOUS PSYCHIATRIC MEDICATION** (if more than 12 medications, please attach a separate list):

Name	Highest Dosage	Duration of Use	Response	Reason for Stopping
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**SUBSTANCE USE:**

Type	Average Usage	Current	Past	When Last Used
Caffeine _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nicotine _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Marijuana _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inhalants _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hallucinogens (LSD/Ecstasy/PCP/Mushrooms) _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Opiates (Heroin/Morphine/Other Narcotics) _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sedatives _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Steroids _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stimulants (Meth/Crack/Cocaine/Crank) _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Synthetic Drugs/Bath Salts _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Misuse of Other Prescription Drugs _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**INDIVIDUAL / GROUP SUBSTANCE ABUSE TREATMENT (AA, NA, etc.):**

Year	Program	Was It Voluntary or Court Mandated?	Was It Productive?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SUPPORT GROUP ATTENDANCE** for other issues (AL-ANON, ACOA, CoDA, OA, etc.)? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

**SOCIAL HISTORY**

**PERSONAL MARITAL / RELATIONSHIP STATUS:**

Single  Married  Cohabiting  Engaged  Separated  Divorced  Re-married  Widowed

Current Spouse or Partner (if applicable) \_\_\_\_\_ Age \_\_\_\_\_

Years Married /Together \_\_\_\_\_ Describe your Relationship \_\_\_\_\_

Number of times Married? \_\_\_\_\_ Divorced? \_\_\_\_\_ Widowed? \_\_\_\_\_

Please List Previous Marriages / Long-term Relationships in order of occurrence (If applicable):

Name	Number of Years Together	Children?	Reason for End
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**CHILDREN:** Please list ALL Children (including step-children and children who do not live with you):

Name of Child	Age	Sex	Live with you?	Describe your relationship with him/her.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list all others who live/stay with you and their relation to you: \_\_\_\_\_

**PARENTS:** Please indicate the current marital/relationship status of your parents:

Married  Cohabiting  Separated  Divorced  Re-married  Widowed

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

How would you describe their relationship with each other when you were growing up? \_\_\_\_\_

If your parents are Divorced, how old were you at the time? \_\_\_\_\_

If one or both Re-married, how old were you at the time? \_\_\_\_\_

With whom did you live afterward? \_\_\_\_\_

Are your parents still living? \_\_\_\_ If not, please list which is deceased, the year, and the cause of death: \_\_\_\_\_

How would you describe your relationship with your mother when growing up? \_\_\_\_\_

Now (if applicable)? \_\_\_\_\_

How would you describe your relationship with your father when growing up? \_\_\_\_\_

Now (if applicable)? \_\_\_\_\_

**SIBLINGS:** Please list ALL siblings (If step or half, indicate the parents you have in common by M=Mother, F=Father, SM=Stepmother, SF=Stepfather; if deceased, write D by name and age died):

Name \_\_\_\_\_ Age \_\_\_\_\_ (Half or Step? Parents) \_\_\_\_\_ Did they live with you? \_\_\_\_\_ Describe your relationship. \_\_\_\_\_

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**EDUCATION:** Highest Level of Education: \_\_\_\_\_ Did you receive Special Education Services in school? \_\_\_\_\_ If yes, please explain. \_\_\_\_\_

Are you currently enrolled in school? \_\_\_\_\_ If yes, where? \_\_\_\_\_

What is your Major/course of study? \_\_\_\_\_

When will you be finished? \_\_\_\_\_

**MILITARY SERVICE:** If no military history, check here:

Branch: \_\_\_\_\_ Dates Served: \_\_\_\_\_

Discharge Rank: \_\_\_\_\_ Type of Discharge: \_\_\_\_\_

Did you sustain physical or psychological injuries in the Military? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

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**EMPLOYMENT:** Please list your work history (beginning with your current/most recent job):

Employer	Position Held	Hrs/Wk	Dates	Reason Left
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Are you Unemployed? \_\_\_\_\_ Seasonally? \_\_\_\_\_ Are you receiving Unemployment? \_\_\_\_\_

Are you on **SICK/MEDICAL LEAVE**? \_\_\_\_\_ **LONG TERM DISABILITY**? \_\_\_\_\_

**WORKERS' COMPENSATION**? \_\_\_\_\_ **SOCIAL SECURITY DISABILITY**? \_\_\_\_\_ **SSI**? \_\_\_\_\_

Are you awaiting resolution of a claim for any of the above? \_\_\_\_\_ If yes, please explain and give your Attorney's name (if applicable): \_\_\_\_\_

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Have you had any **LEGAL PROBLEMS**, past or present? \_\_\_\_\_ If yes, please explain (dates/offenses/incarcerations/current status): \_\_\_\_\_

Were you raised in a **RELIGION / FAITH / SPIRITUAL TRADITION**? \_\_\_\_\_ If yes, which one/ones? \_\_\_\_\_ Do you currently participate in

a church or faith group? \_\_\_\_\_ If yes, where? \_\_\_\_\_

Is religion/faith/spirituality a meaningful part of your private life? \_\_\_\_\_ Please explain (if you are comfortable doing so): \_\_\_\_\_

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Do you have an **ETHNIC HERITAGE** that is an influence on your life? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_



What do you consider to be your **STRENGTHS** that will help you in treatment? \_\_\_\_\_

\_\_\_\_\_

What **COPING SKILLS** have you used in the past? \_\_\_\_\_

\_\_\_\_\_

Who would you say are the most **SUPPORTIVE PEOPLE** in your life? \_\_\_\_\_

\_\_\_\_\_

Will anyone else be involved in your treatment? \_\_\_\_ If yes, who and to what extent? \_\_\_\_\_

\_\_\_\_\_

## MEDICAL HISTORY

**PRIMARY CARE PROVIDER:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

When was your last visit? \_\_\_\_\_ Last physical exam with bloodwork? \_\_\_\_\_

Are there other physicians/specialists you see on a regular basis? \_\_\_\_\_

\_\_\_\_\_

### CHECK IF YOU HAVE EVER HAD:

Loss of Consciousness       Head Injury       Seizures

### CHECK IF YOU HAVE ANY OF THE FOLLOWING:

- |   |   |
|---|---|
| <input type="checkbox"/> AIDS/HIV                   | <input type="checkbox"/> High Blood Pressure                |
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> High Cholesterol                   |
| <input type="checkbox"/> Alzheimer's/Dementia       | <input type="checkbox"/> IBS/Crohn's Disease/Celiac Disease |
| <input type="checkbox"/> Anemia/ Low Iron           | <input type="checkbox"/> Kidney Disease                     |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Liver disease                      |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Menstrual Problems                 |
| <input type="checkbox"/> Blood Disorder             | <input type="checkbox"/> Migraine Headaches                 |
| <input type="checkbox"/> Chronic Back or Neck Pain  | <input type="checkbox"/> Multiple Sclerosis                 |
| <input type="checkbox"/> Chronic Fatigue Syndrome   | <input type="checkbox"/> Obesity                            |
| <input type="checkbox"/> Chronic Nosebleeds         | <input type="checkbox"/> Paralysis/ Loss of Sensation       |
| <input type="checkbox"/> COPD/Emphysema             | <input type="checkbox"/> Parkinson Disease                  |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Prostate Problems                  |
| <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> Skin Conditions/Eczema/Dermatitis  |
| <input type="checkbox"/> GERD (Acid Reflux)/Ulcers  | <input type="checkbox"/> Stroke/ TIA                        |
| <input type="checkbox"/> Hearing Problems           | <input type="checkbox"/> Thyroid problems                   |
| <input type="checkbox"/> Heart Attack/Heart Disease | <input type="checkbox"/> Vision                             |

**Patient Name:** \_\_\_\_\_ **Account:** \_\_\_\_\_ **Page 9 of 10**

Cancer

If yes for cancer, what type and what treatment (if applicable)? \_\_\_\_\_

Surgeries

If yes for surgeries, what type? \_\_\_\_\_

Do you have any other medical problems not listed above? If so, please list here: \_\_\_\_\_

**CURRENT NON-PSYCHIATRIC MEDICATIONS:** (if more than 6, please attach a separate list)

Name	Dosage	Duration	Response

Do you take these medications as prescribed? \_\_\_\_\_ If not, please explain: \_\_\_\_\_

**DRUG ALLERGIES AND REACTIONS:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If someone other than the patient completed or helped complete this form:*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Please Circle: Spouse/Guardian/Legal Representative/Other \_\_\_\_\_)