TRANSFORMATIONS
ADULT AND GERIATRIC PSYCHIATRY PC

MEDICAL & REFERRAL INFORMATION	
Primary Care Physician:	Phone: FAX: Email:
Name of Therapist:	Phone: FAX: Email:
By Whom Were You Referred? Relationship: Phone:	

PAST MEDICAL HISTORY (Please List Conditions in the Boxes Below)		
Are You Pregnant?:		

CURRENT MEDICATIONS		
Name of Medication:	Dosage:	How Many Times per Day?

MEDICATION ALLERGIES	
Name of Medication:	Adverse Reaction:

TRANSFORMATIONS
ADULT AND GERIATRIC PSYCHIATRY PC

FAMILY HISTORY OF MENTAL ILLNESS OR DRUG ABUSE

Relationship of Relative:	Condition:	Suicide?

PAST PSYCHIATRIC HISTORY

Number of Prior Psychiatric Hospitalizations:	Year of Last Hospitalization:

Have You Ever Attempted to Harm Yourself or End Your Life? If So, How:

When Was Your Last Attempt:

PRIOR PSYCHIATRIC MEDICATIONS
(Please List Additional Medications on Back of This Sheet)

Name of Medication	Highest Dosage You Recollect	How Long Did You Take It?

SOCIAL HISTORY

What is Your Marital Status? If Married, How Many Times?

With Whom Do You Live?

Primary Source of Income?

Do You Have Children? If So, Please List Names and Approximate Ages?

Highest Level of Education:

Did You Experience Learning Difficulties as a Child?

Were You Subjected to Any Emotional, Physical, Sexual Abuse in Your Life?
Do You or Have You Ever had Legal Problems? If So, Please Specify:
Do You Struggle with Alcohol or Drug Use?
Have You Ever Experienced Blackouts or Seizures Related to Alcohol or Drug Use?
Have You Ever had DUI Charges? If So, When?
Please List Any Additional Aspect(s) of Your Life History that You Feel Would be Relevant to Your Treatment:

Have you ever had or do you currently have any of the following (check all that apply):

Head Injury with Loss of Consciousness: ..... [ ]

Seizure(s): ..... [ ]

Memory Lapses: ..... [ ]

Unexplained Numbness, Tingling, or Weakness of Any Body Part: ..... [ ]

Neuroleptic Malignant Syndrome: ..... [ ]

Toxic Reactions To Medications or Street Drugs: ..... [ ]

Thyroid, Parathyroid, or Adrenal Problems: ..... [ ]

Sexually Transmitted Diseases or HIV ..... [ ]

Unexplained, Repeated Falls: ..... [ ]

Difficulty Urinating: ..... [ ]

Glaucoma: ..... [ ]

Loud Snoring, Jerky Legs During Sleep, Nightmares, or Daytime Sleepiness: ..... [ ]

Difficulty Driving (repeated accidents, fender benders, etc.): ..... [ ]

Are You Regularly Using Over-the-Counter Medications or Herbal Medications: ..... [ ]

If Yes, Please List:

I CERTIFY THAT I HAVE COMPLETED THIS REGISTRATION FORM TRUTHFULLY TO THE BEST OF MY KNOWLEDGE:

_____ _____

Signature Date