

Psychiatric History Section Completed by:

Name:	Tel:
Position held:	

Referred Individual

Name:

Current Psychiatric Diagnoses (to be completed by health care professional / assigned clinician)

Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	
Axis VI:	
Axis VII:	

Current Medications (Regular and PRN):

Name	Dosage	Frequency



** Please try to be as concise as possible when providing information*

Any known Family Psychiatric History: (i.e., diagnoses/treatments/hospitalizations)

Previous psychiatric, psychological, neurological, or other relevant assessments:

Date	
Agency/Facility	
Assessor	
Type of Assessment	

Date	
Agency/Facility	
Assessor	
Type of Assessment	

Date	
Agency/Facility	
Assessor	
Type of Assessment	

Date	
Agency/Facility	
Assessor	
Type of Assessment	