PSYCHIATRIC INFORMATION

Psychotherapist: Name: ________________________ Phone: ________________
Address: ____

Psychiatrist ____________________ Last seen: _____________Phone: ________________
Address: ____

Any past psychiatric hospitalizations? _______ How many? ______

Month/Year	Hospital Name	Length of Stay	Main reason for hospitalization

Any history of suicide attempts? ❑ Yes ❑ No __________________

Any history of non-suicidal self-injurious behaviors? ❑ Yes ❑ No ____________

Any history of violence? ❑ Yes ❑ No __________________

Dc you have access to firearms? ❑ Yes ❑ No __________________

Any history of trauma/abuse? ❑ Yes ❑ No __________________

Any history of legal problems? ❑ Yes ❑ No __________________

Any history of addiction problems? ❑ Yes ❑ No __________________

Briefly describe what you most want help with now:

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