Karron Maidment, RN, LMFT
Licensed Marriage and Family Therapist
MFT# 41914
Telephone 310 285 2280
1923 1/2, Westwood Blvd. Suite 2. Los Angeles, CA 90025

Initial Visit Health History Form
Please fill out this form prior to your first appointment.

Date:

Patient Information

Name:	**Sex:** **M** ☐ **F** ☐	**Birthdate:**	**Age**
Home Address: (street)		**Cell Phone:**	
City/State/Zip		**Home Phone:**	
Email: (optional)			

Social History

Birth Place:		
Marital Status: Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed ☐		
Highest level of education: Grade School ☐ High School ☐ College ☐ Graduate School ☐		
Employment History: Currently Employed: ☐		Occupation:
Unemployed ☐	Date last worked	Prior Occupation
Retired ☐	Disabled ☐	Disability Diagnosis:
Who lives at home with you?		

Psychiatric History:
Have you previously received psychiatric treatment? YES ☐ NO ☐

What prior diagnosis, if any, have you received?_____

Have you been hospitalized in the past for a psychiatric illness? YES ☐ NO ☐
If yes, how many times have you been hospitalized for a psychiatric illness?
1 ☐ 2-5 ☐ 5-10 ☐ 10-20 ☐
When was your first hospitalization?_____
When was your most recent hospitalization?_____

What prior psychiatric treatments have you tried?

_____
_____
_____
_____
_____
_____

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Are you currently taking medications? YES ☐ NO ☐

If yes, please list ALL medications you are taking, including over the counter medications

Name of medication	Dose	For how long have you been taking this medication?	Any side effects?

Who is your prescribing doctor? Name:_____Phone:_____

Have you ever attempted suicide? YES ☐ NO ☐
If yes, please describe_____
_____

Has anyone in your family attempted or complete suicide? YES ☐ NO ☐

Family History

Indicate if any of your blood relatives has/had any of the following conditions

Health Problem	**Relative Affected**
Alcoholism	
Drug Addiction	
Schizophrenia	
Bipolar Disorder	
Depression	
Anxiety	
Obsessive Compulsive Disorder	
Hoarding Disorder	
Panic Disorder	
High Cholesterol	
Diabetes	
High Blood Pressure	

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Medical History

Do you have any current health problems? YES ☐ NO ☐
If yes, please describe_____

_____

Do you have any allergies? YES ☐ NO ☐
If yes, please describe_____

In case of an emergency, please provide a contact person;

Name:_____Phone: _____
Relationship to you: (spouse, parent)_____

Who is your primary care doctor?
Name:_____Phone: _____

Do you have a psychiatrist? YES ☐ NO ☐
If yes,
Name:_____Phone: _____

PLEASE NOTE THAT MY SERVICES REQUIRE A 24 -HOUR NOTICE OF CANCELLATION. FAILURE TO GIVE 24 -HOUR NOTICE WILL RESULT IN FULL SESSION FEE BEING CHARGED.