Please fill out the paperwork to the best of your ability and answer truthfully.

Thank you.

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COLUMBUS PSYCHIATRY
Kristi Maroni, M.D.

Name: _____DOB:_____

Appointment Date:

_____

Primary Care Physician Name, Address and Phone Number: _____

_____

Person who referred you (Name and Address): _____

_____

Reason for your visit (Please be as detailed as possible): _____

_____

_____

_____

**Medical History:** Please check all that apply to you and your family members and indicate their relationship to you:

| | Self | Family |
|---|---|---|
| Heart Disease | | |
| Stroke | | |
| High Blood Pressure | | |
| Diabetes | | |
| Thyroid Problems | | |
| Cancer | | |
| Seizure | | |

Please use the space below to report any other medical problems not listed above:

_____
_____
_____

Please list any surgeries, medical hospitalizations or history of head trauma including dates:

_____
_____
_____

**Medication allergies: Yes No**

If yes, please list medication and reaction: _____
_____
_____

Please list **all current medications** and dosages including over the counter medication, and vitamin/herbal supplements:

_____
_____
_____
_____

Please list **all past psychiatric medications**, doses and reason for discontinuing (do not include antibiotics or over the counter medicines).

_____
_____
_____
_____
_____

If applicable, date of last menstrual period: _____

Are you pregnant or have you ever been pregnant:_____

Are you breastfeeding: _____

What form of birth control are you using, if any: _____

**Past Psychiatric History:**

Previous diagnosis: _____

Previous Outpatient Psychiatrist: _____

Previous Outpatient Therapist/Counselor: _____

Previous Psychiatric Admissions, Dates and Locations:

_____

_____

_____

Previous Suicide Attempts, how and when:

_____

_____

_____

Any Self Injurious Behaviors (cutting, burning, hair pulling):

_____

_____

**Family Psychiatric History:**

Depression: _____

Bipolar: _____

PTSD: _____

Schizophrenia: _____

Eating Disorder: _____

ADHD: _____

Developmental Disorder: _____

Asperger's/Autism: _____

Cutting: _____

Psychiatric Admissions: _____

Suicide Attempts: _____

Completed Suicides: _____

Alcohol Abuse: _____

Drug Abuse: _____

Drug/Alcohol Treatment: _____

**Social History:**

Where were you born and raised? _____

Who lives at home with you? _____

Please list names and ages of all brothers and sisters:

Brothers: _____

Sisters: _____

Are your parents still alive? **Yes No**

If not, how and when did they die? _____

Are your parents ____ married, ____ not married but living together, ____ together but living separately,

____ divorced or ____ separated?

Do you have any children? If so, give names and ages: _____

Are you employed? **Yes No**

Where? _____ How Long? _____

As a child were you ever placed in foster care? **Yes No**

**If yes, please explain:**

_____
_____
_____
_____

**Academic History:**

Are you in school currently? **Yes No**

What school/college do you attend? _____

Did you graduate high school? _____

If you are in college, what year are you in? _____

What were your grades typically in school? _____

Were you ever retained/suspended or expelled in school? **Yes No**

If yes, please explain: _____

Did you ever require a 504 or IEP in school? **Yes No**

If yes, please explain: _____

Any Military history? **Yes No**
If yes, which branch? _____
If yes, how long did you serve or are you still serving?
_____
If you have been discharged, was it honorable? _____
Do you have VA benefits? **Yes No**

Any legal history, as in, have you been charged with anything? **Yes No**

If yes, please explain:

_____
_____
_____

Are you on probation or parole? _____

Any history of physical or sexual abuse? **Yes No**
If yes, please explain:

_____
_____
_____
_____

Any history of witnessing domestic violence or being a victim of domestic violence? **Yes No**
If yes, please explain:

_____
_____
_____
_____

Do you own or have access to firearms? **Yes No**
If yes, how many, where and are they locked up:

_____
_____

**Substance Use:**

Have you ever drunk alcohol? **Yes No**

If yes, how old were you when you started? _____

What did/do you drink? _____

How often did/do you drink? _____

_____

Any history of blackouts if you drank too much? **Yes No**

Any history of withdrawal if you stopped drinking? **Yes No**

Any history of treatment for alcohol use? **Yes No**

If yes, please explain: _____

_____

Any history of legal consequences from alcohol use? **Yes No**

If yes, please explain: _____

_____

Have you ever used illegal drugs or abused prescription medications? **Yes No**
If yes, how old were you when you started? _____

What do/have you used?

_____

_____

_____

How often did/do you use? _____

_____

Any history of withdrawal from drug use? **Yes No**

Any history of treatment for drug use? **Yes No**

If yes, please explain: _____

_____

Any history of legal consequences from your drug use? **Yes No**

If yes, please explain: _____

_____

Have you ever abused over the counter medication? **Yes No**

If yes, what have you used: _____

_____

_____

Do you smoke? **Yes No**

If yes, how much/how long? _____

How much caffeine do you use/drink in a typical day? (ex. Coffee, tea soda, chocolate, energy drinks)

_____

What are your hobbies or anything that you enjoy doing?

Do you have a support system, people that you can turn to in time of need?

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