CPWC Psychiatric Prescreen Form

Name____**Date**____________________

Date of Birth _____________________ **Primary Care Physician**____

Current Therapist/Counselor____________________________ **Therapist's Phone**_________________________

Referred by: ____

If changing providers indicate the reason for the change: ____

____

What are the problem(s) for which you are seeking help?

1.____

2.____

3.____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date Prescriber

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Current medical conditions: ____

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Past Psychiatric History: Outpatient treatment ☐ Yes ☐ No If yes, please describe for what reason, when and where, and by whom.

Reason Dates Treated By Whom

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Psychiatric Hospitalization ☐ Yes ☐ No If yes, please describe for what reason, when and where.

Reason Date Hospitalized Where

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