Portable Health Record

Patient Name: _____ Phone Number: _____ Date: _____

Emergency Contact Name: _____ Phone Number: _____

Previous Psychiatric Inpatient Hospitalization(s): (Select One) ☐Yes ☐No

1. Type of Inpatient Stay (Select One): ☐Voluntary ☐Involuntary
Where _____ When _____ For How Long _____

2. Type of Inpatient Stay (Select One): ☐Voluntary ☐Involuntary
Where _____ When _____ For How Long _____

3. Type of Inpatient Stay (Select One): ☐Voluntary ☐Involuntary
Where _____ When _____ For How Long _____

4. Type of Inpatient Stay (Select One): ☐Voluntary ☐Involuntary
Where _____ When _____ For How Long _____

Current Psychiatrist (or Provider): _____ Phone Number: _____

Address: _____

Diagnosis: _____

Current Medications

Medication: _____ Dosage: _____ Date Started: _____

Medication: _____ Dosage: _____ Date Started: _____

Medication: _____ Dosage: _____ Date Started: _____

Medication: _____ Dosage: _____ Date Started: _____

NOTES:

Detailed Treatment History

Name of Psychiatrist (or Provider): _____

Location: _____ Treatment Date Range: _____

Diagnosis: _____

Medication: _____ Dosage: _____ Date Started: _____Date Ended: _____

Side Effects: _____

Medication: _____ Dosage: _____ Date Started: _____Date Ended: _____

Side Effects: _____

Medication: _____ Dosage: _____ Date Started: _____Date Ended: _____

Side Effects: _____

Medication: _____ Dosage: _____ Date Started: _____Date Ended: _____

Side Effects: _____

Medication: _____ Dosage: _____ Date Started: _____Date Ended: _____

Side Effects: _____

Was the treatment helpful? Rate 0-10, 10 being most helpful. (Please Select)

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Notes:

Portable Health Record

Therapist (&/or Other Providers):

1. (Select One): ☐Therapist ☐Other Provider

Name: _____

Location: _____ Date Range of Care: _____ Diagnosis (if applicable): _____

Was the treatment helpful? Rate 0-10, 10 being most helpful. (Please Select)

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Notes:

2. (Select One): ☐Therapist ☐Other Provider

Name: _____

Location: _____ Date Range of Care: _____ Diagnosis (if applicable): _____

Was the treatment helpful? Rate 0-10, 10 being most helpful. (Please Select)

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Notes:

3. (Select One): ☐Therapist ☐Other Provider

Name: _____

Location: _____ Date Range of Care: _____ Diagnosis (if applicable): _____

Was the treatment helpful? Rate 0-10, 10 being most helpful. (Please Select)

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Notes:

Chemical/Drug Abuse (Select One): ☐Yes ☐No

Type of Drug: _____ Date First Used: _____ Date Last Used: _____

Type of Drug: _____ Date First Used: _____ Date Last Used: _____

Type of Drug: _____ Date First Used: _____ Date Last Used: _____

Type of Drug: _____ Date First Used: _____ Date Last Used: _____

Type of Drug: _____ Date First Used: _____ Date Last Used: _____

Alcohol Use? ☐Yes ☐No Date First Used: _____ How Much: _____ How Often: _____ Date Last Used: _____

Chemical/Drug Abuse Treatment History

1. Name of Provider: _____ Location: _____ Treatment Date Range: _____

Notes: _____

2. Name of Provider: _____ Location: _____ Treatment Date Range: _____

Notes: _____

3. Name of Provider: _____ Location: _____ Treatment Date Range: _____

Notes: _____

Family History of Substance Use or Mental Illness (Select One): ☐Yes ☐No

1. Family Member Name: _____ Relationship to Patient: _____ Psychiatric Diagnosis: _____

Substance Use? ☐Yes ☐No Type of Drug: _____ Alcohol Use: ☐Yes ☐No

2. Family Member Name: _____ Relationship to Patient: _____ Psychiatric Diagnosis: _____

Substance Use? ☐Yes ☐No Type of Drug: _____ Alcohol Use: ☐Yes ☐No

Other Pertinent Information:

Current Living Situation: _____ ☐Married ☐Single ☐Divorced Children: ☐Yes ☐No Please list any family who is part of the patients support system: _____ Latest Education: _____

Working : ☐Yes ☐No Occupation: _____ Current Legal Issues: _____