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Asheville, NC 28801

Patient History

Name: ______________________________________ Date of birth: __________________

Marital status: ___________________ Children's ages (if any): _______________________

History of chronic illnesses (e.g., high blood pressure, diabetes): _________________________

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History of surgeries: ____

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Medications:

Name	Dosage and frequency
_________________________	_______________________________
_________________________	_______________________________
_________________________	_______________________________
_________________________	_______________________________
_________________________	_______________________________
_________________________	_______________________________

Allergies: ____

Alcohol:

On average, how many days per month do you drink? ____________________________

On average, how many standard drinks (12 oz. beer, 5 oz. wine, 1.5 oz. liquor) do you have on days that you drink? ____

Do you smoke cigarettes? No_____ Yes_____ , _____ packs per day

Other substances (which, how much, how often): _______________________________________

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Occupation: ____

Education: ____

Who lives in your home? ____

Family history of mental illness: ____

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Family history of addiction: ____

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Today's date: ___________________________