

PSYCHIATRIC / MEDICAL BACKGROUND

CURRENT PSYCHIATRIC DIAGNOSIS	DOES CLIENT UNDERSTAND NEED FOR MEDS?	Y	N	N/K
	WILLING AND PREPARED TO TAKE MEDS?			
	IF UNSUPERVISED, FORGETS TO TAKE MEDS?			
	KNOWN TO HIDE OR FEIGN TAKING MEDS?			
DEGREE OF MENTAL HANDICAP (RETARDATION)	ANY KNOWN OR OBSERVABLE SIDE EFFECTS? (DESCRIBE)			

ALCOHOL/DRUG/SMOKING PROBLEMS (SPECIFY)

MEDICATION	DOSE	FREQUENCY	ROUTE	PRESCRIBED BY	APPROX. DATE

ALLERGIES

DESCRIBE KNOWN STRESSFUL FACTORS

HAVE THERE BEEN ANY TRAUMATIC EVENTS IN THIS PERSON'S LIFE?
 YES NO N/K IF YES, GIVE DETAILS

DESCRIBE SIGNS OF DECOMPENSATION

PHYSICIAN (G.P. / FAMILY)	ADDRESS	TELEPHONE
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PSYCHIATRIC HOSPITALIZATIONS ACUTE HOSPITAL PSYCHIATRIC UNIT; DAYCARE; FORENSIC PSYCHIATRIC INSTITUTE; RIVERVIEW NONE NOT KNOWN

NAME OF HOSPITAL	DATE OF ADMISSION/DISCHARGE	REASON FOR ADMISSION

DESCRIBE CURRENT AND PAST MAJOR MEDICAL ILLNESS (NON PSYCHIATRIC; ANY SURGERY)

ASSESSMENT DATE	YYYY	MM	DD	CLIENT FAMILY NAME
CLIENT NUMBER				