The Seattle Arthritis Clinic

NAME ______________________________ DATE ________________________

PATIENT INFORMATION FORM

CONFIDENTIAL INFORMATION: This form is intended to save time and to help provide the best service possible. All information on this form is considered confidential. Please answer as carefully and completely as possible. If you require additional space, please continue your answers on the back of the page.

What do you hope to gain from this session?
1.

2.

3.

4.

5.

Health

List the five problems of greatest concern to you.

Describe your problems in your own words.

Prior illnesses, accidents, operations:

Allergies:

Current Health:

Current Medications:

Names and addresses of all physicians and health care providers:

Treatments you had with each provider listed above (please include dates):

Have you received any prior psychiatric or other mental health evaluation or treatment? If yes, please describe.

Personal Data

Place and date of birth:

How many times have you moved in the past five years?

Do you drink alcoholic beverages?

If yes, please describe your drinking.

Do you use any other illicit drugs?

If yes, please describe their use.

Present interests, hobbies, and activities:

Educational History

	How many attended?	Completed?	Year Completed
Grade school			
Middle school			
High school			
College			

Military Service History

Branch:

Discharge Status:

Dates of service:

Outside USA?

Where?

Hazardous or combat duty?

Occupational History

What is your current position?

Who is your current employer?

How long have you been in your current position?

Please list the jobs you have held in the past, going back 15 years.

Employer	Job Title or Description	Approximate Dates

Marital History

Marital Status: Single _________ Divorced _________ Widowed_________
Married _______ Separated________ Remarried________

If married or remarried, year of marriage:

If divorced, widowed, or separated, for how long?

Spouse's current age (or age at time of death):

Spouse's occupation:

Spouse's health (or cause of death):

Any previous marriages for you?

Any previous marriages for your spouse?

Children

Full Name	Sex	Age	Whereabouts

Legal

Have you ever had any involvement with the legal justice system, either criminal or civil?

If yes, please describe

If you have an attorney, please list the following:

Name:

Address:

City/State/Zip:

Telephone:

Family Data

Mother:

Living or deceased:

If alive, mother's present age:

Mother's health:

Whereabouts:

How often do you have contact with her?

Mother's occupation:

If deceased, your age at the time of her death:

Cause of death:

Father:

Living or deceased:

If alive, father's present age:

Father's health:

Whereabouts:

How often do you have contact with him?

Father's occupation:

If deceased, your age at the time of his death:

Cause of death:

Please place a checkmark in the appropriate box if the following conditions have been present in relatives

	Children	Sisters	Brothers	Mother	Father	Aunts/Uncles
Nervous problems						
Depression						
Drinking problems						
Drug problems						
Psychiatric treatment						

Siblings

Full Name	Sex	Age	Whereabouts

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Other

Please list any other information which you think might be of assistance in understanding and helping you.