



**PSYCHIATRIC & ADDICTION SERVICES**  
Ralph Bharati M.D., P.A.

**Past Psychiatric History Form**

**Patient Information**

Patient Name: \_\_\_\_\_ ID #(office use only): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Psychiatric History**

Have you received psychological or psychiatric Evaluations in the past? YES NO

If YES, list name of doctor, period of time you saw this doctor and types of services received:

- 1) 2)
- 3) 4)

Have you been hospitalized for mental health or chemical dependency in the past? YES NO

If YES, list name of hospital, where it was located, when you were hospitalized, your doctor and diagnosis:

- 1) 2)
- 3) 4)

Have you received psychotherapy or counseling in the past? YES NO

If YES, list name of professional, where and when you saw them:

- 1) 2)
- 3) 4)

Have you been on psychiatric medications in the past? YES NO

If YES, please list names of medication, dosage, doctor who prescribed, period of time you took the medication and any side effects you experienced:

- 1) 2)
- 3) 4)