

**Health and Mind, LLC/  
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**PATIENT'S BRIEF HISTORY**

Name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Briefly describe the reason for your visit( your current symptoms and treatment): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Psychiatric Treatment History:**

Outpatient treatment: \_\_\_\_\_ Yes, \_\_\_\_\_ No

Inpatient treatment: \_\_\_\_\_ yes, \_\_\_\_\_ No

History of suicide attempts: \_\_\_\_\_ yes, \_\_\_\_\_ No

Current Psychiatric medications:

\_\_\_\_\_  
\_\_\_\_\_

Substance/Alcohol abuse: yes,\_\_\_\_\_, no \_\_\_\_\_

If yes, Current: \_\_\_\_\_, Past: \_\_\_\_\_

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History:**

\_\_\_\_\_  
\_\_\_\_\_

**Allergies:**

\_\_\_\_\_  
\_\_\_\_\_

Current medications for Medical issues:

\_\_\_\_\_  
\_\_\_\_\_

Family history of mental health or substance/alcohol abuse issues:

\_\_\_\_\_  
\_\_\_\_\_

Childhood issues(trauma, academic difficulties, developmental delays):

\_\_\_\_\_  
\_\_\_\_\_

Educational level: \_\_\_\_\_ Employment: \_\_\_\_\_

Legal issues: no\_\_\_\_\_, yes \_\_\_\_\_

If yes, describe: \_\_\_\_\_