JohnGeremia, LCSW-C
PSYCHOTHERAPIST

MENTAL HEALTH HISTORY

Have you taken **psychotropic medication in the past**? ◯ yes ◯ no
If yes:
Name *Reason for discontinuation*

Please list, *chronologically*, your experiences in **therapy and/or psychiatric treatment:**
Dates *Reason* *Therapist /Psychiatrist/ Hospital* *Frequency of visits / Helpful?*

Please list anyone in your **family** (including extended family members), present or with history of psychiatric and/or therapy treatment:
Relationship to You *Diagnosis/Issue* *Type of Treatment, including medication, if known*

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