THE STELLATE INSTITUTE™
TREATING THE INJURY OF TRAUMA

Patient History Form

Name: _____ Date: _____

Contact email: _____

Contact phone number: _____

Patient History Form:

1. Are you: Active duty military or a Veteran? ☐Yes ☐No

☐USA ☐USN ☐USAF ☐USMC ☐USCG

2. Are you a first responder? (Law Enforcement, EMS, Firefighter) ☐Yes ☐No

3. Have you had a traumatic experience? ☐Yes ☐No
(We do not require details of your traumatic experience to successfully treat you)

4. Which category of trauma best describes your traumatic experience?

☐Combat-related

☐Sexual abuse or assault

☐Childhood abuse or neglect

☐First responder related trauma

☐Domestic/Intimate Partner Violence

☐A life-threatening event (car accident, medical emergency)

5. Have you ever been under the care of a behavioral health professional? ☐Yes ☐No

Who: Name: _____ When: _____

Address: _____

Phone#: _____ Fax#: _____

6. Do you have a mental health diagnosis? ☐Yes ☐No

(Please name each diagnosis you have)

☐PTSD ☐Anxiety ☐Depression ☐Bipolar ☐Other: _____

7.. What are your most troubling symptoms?

☐Unwanted memories/nightmares ☐Negative feelings (guilt, shame) ☐Sleep difficulties
☐Irritability/Angry outbursts ☐Easily startled/Jumpy ☐ Other: _____

8. Are you (or could you be) pregnant? ☐Yes ☐No

9. Do you have an intense and disabling fear of vomiting? ☐Yes ☐No

10. Do you have a diagnosis of traumatic brain injury (TBI)? ☐Yes ☐No

11. Are you on any medications that thin your blood? ☐Yes ☐No

☐Aspirin ☐Coumadin ☐Eliquis ☐Heparin ☐Other: _____

12. Please list any medications you are currently taking.

13. Please list any allergies to medications that you have.

14.Please check any medical conditions that you have been diagnosed with.

☐Diabetes ☐Chronic Lung Disease ☐Hypertension ☐Other: _____

15. Do you drink alcohol? If so, how often?

☐Zero ☐Less than 7 drinks/week ☐7-14 drinks/week ☐More than 14 drinks/week

16. Height: _____ 17. Weight: _____

18. How did you hear about us? _____

19. What is your current occupation? _____