Depression and Treatment History Form

Name: _____ Date: _____

PCP: _____ Psychiatrist: _____

Therapist: _____

Current and Past Depression Medication Trials (Please fill at least Four previous medications)

Medication Name	Dosage (mg)	From Date	To Date	Current Medication (Y/N)	Side Effects or Reason(s) for Discontinuation

Current and Past Therapy Information

Therapist Name	License (Psy.D, LCSW, LCPC etc)	From Date	To Date	Treatment Modality	Frequency	Reason for discontinuation of Therapy