Medical History

Client Name:_____Date of Birth:_____Age:_____.

A: Circle any adjective that describes your present state of health:

Excellent Good Fair Poor

B: List any prescribed medications you are now taking, including dosages:_____
_____
_____

C: List any history of serious illness in your family including mental illness or substance abuse:_____
_____
_____

D: List and describe any previous psychiatric hospitalizations:_____
_____
_____

E: Do you smoke?_____ If "yes" how much?_____
Do you drink alcohol?_____ If "yes" how much/what type?_____

F: Give dates and describe any history of counseling including supervisory referrals:_____
_____
_____

G: Have you ever had any of the following conditions or symptoms?

Trouble Sleeping	_____	Appetite Changes	_____
Fainting	_____	Low Energy	_____
Headaches	_____	Crying Spells	_____
Memory Problems	_____	Irritability	_____
Stomach Trouble	_____	Trouble Concentrating	_____
Anxiety	_____	Indecisiveness	_____
Depression	_____	Unexplained Pain	_____
Numbness or Tingling	_____	Thoughts about Suicide	_____
Problems with Anger	_____	Extreme Nervousness	_____
Emotional/Physical/Sexual Abuse	_____	Seeing or Hearing things not real	_____
Weight Loss/Gain	_____	Obsessions	_____
Repetitive Irrational Behavior	_____	Nightmares	_____