Medical/Psychiatric Information

Name: ____

Primary Care Physician: ___________________________ Phone Number:______________________

Address: _______________________________________ Date of Last Physical: __________________

How would you rate your overall physical health? ☐Good ☐ Moderate ☐ Fair ☐ Poor

Current medical problems: ____

____

List ALL current prescription medications: (if none, write none)

Medication Name/Reason Dosage Estimated Start Date

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Current over-the-counter medications or supplements: ____

____

Allergies: ____

Non-psychiatric hospitalization or surgeries: ____

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Medical History: Current/Past Medical Conditions

☐Heart Disease	☐Anemia	☐Headaches/ Migraines	☐Stroke	☐Arthritis	☐Hepatitis
☐Shortness of breath	☐Asthma	☐Diabetes	☐Kidney Problems	☐Cancer	☐Menstrual Problems
☐High Cholesterol	☐Hormone Imbalance	☐Dementia	☐Liver Problems	☐Thyroid	☐Sleep Apnea
☐High Blood Pressure	☐Seizures/ Epilepsy	☐Head Trauma	☐Ulcers	☐Fibromyalgia	☐Smoke

Other: ____

Family History Of Illness/Disease

☐ None	☐ Cancer	☐ Asthma	☐ Heart Disease
☐ Diabetes	☐ High Blood Pressure	☐ Thyroid	☐ Epilepsy
☐ Dementia/Alzheimer’s	☐ Hormone Imbalance	☐ Migraines	☐ Other:

Please Turn Over and Complete the Backside

Your Exercise Level:

Do you exercise regularly? ☐ Yes ☐ No

How many days a week do you get exercise? ______________________________

How much time each day do you exercise? ______________________________

What kind of exercise do you do? ______________________________

Psychiatric History

Is there family history of any of the following?

MOTHER:	FATHER:	SIBLINGS:	EXTENDED FAMILY/ GRANDPARENTS
☐ ADD/ADHD	☐ ADD/ADHD	☐ ADD/ADHD	☐ ADD/ADHD
☐ Alcohol Addiction	☐ Alcohol Addiction	☐ Alcohol Addiction	☐ Alcohol Addiction
☐ Substance Abuse	☐ Substance Abuse	☐ Substance Abuse	☐ Substance Abuse
☐ Anxiety	☐ Anxiety	☐ Anxiety	☐ Anxiety
☐ OCD	☐ OCD	☐ OCD	☐ OCD
☐ Depression	☐ Depression	☐ Depression	☐ Depression
☐ Bipolar	☐ Bipolar	☐ Bipolar	☐ Bipolar
☐ Eating Disorder	☐ Eating Disorder	☐ Eating Disorder	☐ Eating Disorder
☐ PTSD	☐ PTSD	☐ PTSD	☐ PTSD
☐ Schizophrenia	☐ Schizophrenia	☐ Schizophrenia	☐ Schizophrenia
☐ Anger Management	☐ Anger Management	☐ Anger Management	☐ Anger Management
☐ Personality Disorder	☐ Personality Disorder	☐ Personality Disorder	☐ Personality Disorder
☐ Attempted Suicide	☐ Attempted Suicide	☐ Attempted Suicide	☐ Attempted Suicide
☐ Completed Suicide	☐ Completed Suicide	☐ Completed Suicide	☐ Completed Suicide
☐ Other:	☐ Other:	☐ Other:	☐ Other:

Psychiatric Hospitalizations ☐ Yes ☐ No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

____

____

____

Have you had a previous diagnosis of:

☐Anxiety ☐Depression ☐Panic ☐ADHD ☐OCD ☐Bipolar ☐Anorexia ☐Bulimia ☐PTSD

☐Substance Abuse ☐Alcoholism

Have you received counseling in the past? ☐ Yes ☐ No Did you find it helpful? ☐ Yes ☐ No

When and how long? ______________________________

If yes, what were the issues? ______________________________

Counselor's Name:______________________________