MEDICAL/PSYCHOLOGICAL INFORMATION

NAME _____ ***DATE*** _____

FAMILY PHYSICIAN (PEDIATRICIAN) _____ **PHONE** _____

PHYSICIAN ADDRESS _____ **DATE OF LAST VISIT:** _____

NAMES, RELATIONSHIPS, and AGES of all persons in your HOUSEHOLD:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

REASON FOR TODAY'S VISIT HERE: _____

CURRENT STRESSORS: _____

MARITAL STATUS: Married ___ Single ___ Divorced ___ Cohabiting ___ Widowed ___ No. of marriages _____

LEVEL of EDUCATION: Last grade completed _____ College degrees completed: _____

EMPLOYMENT: Number of jobs held in past five (5) years ___ Current employment: _____

LEGAL PROCEEDINGS: Current ___ Past ____ Nature of proceedings: _____

Have YOU or any biological RELATIVE suffered from any of the following:

Alcohol or drug problems	Yes	No	Self	Family member
Depression or Bipolar	Yes	No	Self	Family member
Anxiety or "Nerve" problem	Yes	No	Self	Family member
Schizophrenia	Yes	No	Self	Family member
ADHD/ADD	Yes	No	Self	Family member

Please list all medications (prescription and over-the-counter) taken within the last six (6) months and the dosages:

_____

_____

Please circle any of the following symptoms you have experienced in the last three (3) months:

Allergies	Constipation	Frequent cough	Abdominal pain/cramps	Diarrhea
Difficulty breathing	Back Pain	Difficulty Sleeping	Difficulty swallowing	Irritability
Blackouts/Amnesia	Lightheadedness	Memory problems	Blurred Vision	Headaches
Nausea or vomiting	Impotence	Night sweats	Change in speech (slurring)	Fainting
Change in sex drive	Restlessness	Ringing in your ears	Palpitations/racing heartbeat	Worry
Chest pain	Weight gain/loss	Panic attacks	Concentration problems	Rage/anger
Nervousness	High blood pressure	Nausea/vomiting	Excessive dieting	Impulsivity

Indicate whether you use any of the following and how much:

Smoke tobacco _____ Smoke marijuana _____ Drink alcohol _____ Drink caffeinated drinks _____

Prior THERAPY or PSYCHOLOGICAL TREATMENT or HOSPITALIZATIONS (Therapist/hospital names and dates):

_____

_____

Please list any significant ILLNESSES, INJURIES, & SURGERIES and approximate dates: _____

_____