Client Name: _____ Date: _____

Date of Birth: _____ Age: _____

MEDICAL / PERSONAL HISTORY

- **What are you seeking treatment for? _____**

_____

- **PLEASE LIST ANY PREVIOUS HOSPITALIZATIONS:**

YEAR	CITY	ILLNESS	HOW LONG	HOSPITAL

- **List any serious illnesses during the past 5 years**: _____

_____

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION	DOSAGE	#TIMES DAILY

- **CHECK ANY OF THE FOLLOWING SYMPTOMS OR CONDITIONS YOU HAVE HAD IN YOUR LIFETIME:**

☐	Blurred Vision	☐	Diabetes	☐	Smoker's Cough
☐	Double Vision	☐	Kidney or Urine Infection	☐	Hearing Loss
☐	Severe Headaches	☐	Blood in Urine	☐	Swollen Ankles
☐	Blackout	☐	Back Pain	☐	Bruise Easily
☐	Seizure	☐	Allergies	☐	Weakness in Arms or Legs
☐	Loss of Consciousness	☐	Hemorrhoids	☐	Venereal Disease (VD)
☐	Dizzy Spells	☐	Hepatitis	☐	Reaction to Medications
☐	Head Injury	☐	Jaundice (yellow skin)	☐	Blood Transfusions
☐	Vomited Blood	☐	Shortness of Breath	☐	Broken Bones
☐	Blood in Bowel Movement	☐	Chest Pains	☐	Sinus or Frequent Colds
☐	Excessive Blood Loss	☐	Heart Attacks	☐	Tuberculosis
☐	Stomach Pain	☐	Pneumonia		

- **FAMILY: Has anyone in your family (parents, brothers, sisters, aunts, uncles, cousins, and children) had any of the following? Please check**:

☐	Kidney Disease	☐	Tumors	☐	Mental Illness
☐	Heart Disease	☐	Diabetes	☐	Epilepsy
☐	Cancer	☐	Tuberculosis	☐	Nervous Disorders

- **PLEASE CHECK WHICH SYMPTOMS OR CONDITIONS YOU ARE EXPERIENCING <u>NOW</u> OR IN THE <u>PAST</u>.**
  - Circle those you are currently taking medication for.

	Present	Past		Present	Past
Insomnia (difficulty sleeping)	☐	☐	Depression	☐	☐
No appetite	☐	☐	Overeating	☐	☐
Alcohol Abuse	☐	☐	Mood Swings	☐	☐
Alcoholism	☐	☐	Excessive Worries	☐	☐
Crying Spells	☐	☐	Fears or Phobias	☐	☐
Hallucinations	☐	☐	Confusion	☐	☐
Difficulty Concentrating	☐	☐	Frequent Loss of Temper	☐	☐
Compulsions	☐	☐	Weight Changes	☐	☐
Extreme Nervousness	☐	☐	Weight Loss/Gain	☐	☐
Can't keep a job	☐	☐	Fingernail Biting	☐	☐
Frequent employment change	☐	☐	Lack of Confidence	☐	☐
Fire setting past age 8	☐	☐	Blaming others frequently	☐	☐
Indecisiveness	☐	☐	Low Self-Esteem	☐	☐
Frequent Accidents	☐	☐	Sexual Problems	☐	☐
Nightmares	☐	☐	Extreme Loneliness	☐	☐
Palpitations	☐	☐	Bowel Disturbances	☐	☐
Feeling Tense	☐	☐	Unable to relax	☐	☐
Don't like weekends	☐	☐	Can't make friends	☐	☐
Financial problems	☐	☐	Fainting Spells	☐	☐
Fatigue	☐	☐	Feeling Panicky	☐	☐
Suicidal Ideation	☐	☐	Inferiority Feelings	☐	☐

	Present	Past		Present	Past
Memory Problems	☐	☐	Irritability	☐	☐
Drug Abuse	☐	☐	Taking Drugs	☐	☐
Bedwetting past age 6	☐	☐	Tremors	☐	☐
Shy with People	☐	☐	Can't make decisions	☐	☐
Home conditions stressful	☐	☐	Concentration difficulties	☐	☐
Unable to have a good time	☐	☐	Sleeping too much	☐	☐

List all previous psychological or psychiatric counseling or treatment:

- **When:**_____ Where:_____

Reason: _____

- **When**:_____ Where:_____

Reason: _____

- **When**:_____ Where:_____

Reason: _____

Have you ever attempted suicide? Yes No When? _____

Have you ever overdosed from a drug? Yes No When? _____

Has anyone in your immediate family (spouse, parents, children, brothers, sisters) ever had any psychological or psychiatric treatment or counseling, or been hospitalized for mental, emotional or nervous disorders?

YES or NO

If yes, who? _____

What do you know about it?

_____

_____

FAMILY ORIGIN:

Relation	Alive or Deceased?	Current Age	Occupation	Cause of Death	Your Age at Death
Father					
Mother					
Sibling					
Sibling					
Sibling					
Sibling					

- **Are there any other members of the family about whom information regarding illness is relevant?**_____

DRUG AND ALCOHOL USE:

- How much of the following substances do you use on a weekly basis?

	PRESENT	PAST
Glasses of Wine	_____	_____
Cans or bottles of beer	_____	_____
Shots of hard liquor	_____	_____
Marijuana	_____	_____
Cocaine	_____	_____
Pills (upper / downer)	_____	_____
Crystal Meth	_____	_____
Heroin	_____	_____
Other – Please describe	_____	_____

Client Signature: _____

Medical History Form was Reveiwed by: _____Date: _____