Medical History

Name _____ Date of Birth_____ Age_____

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

Excellent Good Fair Poor

B. List any prescribed medications you are taking now, including dosage and prescribing doctor:

_____
_____
_____
_____

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?_____

F. Do you drink alcohol?_____ If yes how much?_____

G. Give dates and describe any history of counseling including supervisory referrrals:_____
_____
_____

H. 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_____