Medical Information

Name_____Soc. Sec. #_____Date_____

What is the reason you are seeking help at this time:_____

_____

Please check the items below which apply to you in the past six months

_____ Change of Appetite
_____ Loss of weight
_____Weight Gain
_____ Binge or purge
_____ Worried about your weight
_____ Trouble sleeping
_____ High energy
_____ Low energy
_____ Restless/difficulty sitting still
_____ Anxious or nervous
_____ Loss of interest
_____ Feel like mind playing tricks

_____Worried about your appearance
_____ Forgetfulness or memory problems
_____ Anger
_____ Verbal fighting
_____ Physical fighting
_____ Sexual problems
_____ Difficulty concentrating
_____ Racing thoughts
_____ Sad or depressed
_____ Crying spells
_____ Thoughts of suicide
_____ Self hurt/harm

Have you ever had counseling/therapy or medication for any of the above?_____Yes_____ No
If "Yes", where, when, and from whom?_____

_____

When did you last have a complete physical exam?_____
Who is your primary care physician?_____
How do you rate your overall health? _____Excellent_____Good_____Fair_____Poor
What is your main concern about your health?_____

_____

Any other medical problems? If "Yes", please describe._____

_____

_____

Please complete the following regarding your current medication:

Name of Medication/Herbs	Prescription Yes/No	When prescribed	Amt. Daily	Reason

[Over]

Do you have any allergies? If "Yes" please describe._____

_____

Do you currently use illicit drugs? _____Yes_____ No
Have you ever abused prescription or illicit drugs? _____Yes_____ No
Do you drink alcohol? _____Yes_____ No
How many times per week?_____
On an average, how many drinks per time?_____
Do you use nicotine? ☐Yes ☐No. How much ?_____ Do you use caffeine?☐ Yes☐No How Much ?_____

Have you ever:

Thought you should cut down on your drinking or drug use? ___Yes ___ No
Been annoyed when others have asked you about your drinking or drug use? ___Yes ___ No
Felt guilty about how much you drink or use? ___Yes ___ No
Had a drink/used to get going or to treat a hangover? ___Yes ___ No
Has anyone complained about your drinking/using? ___Yes ___ No
Gotten into trouble with the law, family members, friends when you drink/use? ___Yes ___ No
Do you usually get into trouble when you drink/use? ___Yes ___ No

Do you gamble? _____Yes _____No
How many times per month?_____
What percent of your monthly income do you spend per month on gambling?_____
Have you ever felt the need to bet more & more money?_____
Have you ever had to lie to people important to you about the extent of your gambling?_____

Please check the items below which describe medical symptoms you have had in the past 12 months.

_____persistent cough
_____thyroid disease
_____abnormal heartbeat
_____severe/persistent headaches
_____seizures
_____muscle weakness
_____joint/aches/pains
_____kidney infection/disease
_____urinary infection
_____stomach/abdominal pains
_____change in vision/trouble with eyes
_____change in sense of smell
_____pain in mouth or trouble swallowing
_____speech problem
_____pain/lump/drainage from breasts
_____shortness of breath
_____high blood pressure
_____balance problems/falling
_____loss of consciousness
_____numbness or weakness of limbs/body
_____muscle pain
_____bruise easily
_____trouble urinating
_____liver disease
_____vomiting
_____changing in hearing/trouble with ears
_____feeling clumsy or dropping things.
_____sore/swollen neck/glands
_____voice problems

Signature_____

Signature of parent if completed on behalf of a minor child_____

Therapist signature_____ Date reviewed_____
Referred for physical exam? _____ Yes _____No
To whom_____ Client willing to accept referral _____ Yes _____ No
Referred for psychiatric evaluation? _____Yes _____No
To whom_____ Client willing to accept referral _____ Yes _____ No