Medical History **Today's Date: _____**

Name: _____ Date of Birth: _____ Age: _____

Primary care physician: _____ Phone: _____

Present state of health [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Prescription medications:

Medication	Dosage	For what condition?

What physical symptoms are you currently experiencing? _____

Date of last complete physical exam: _____ Do you exercise regularly? [ ] Yes [ ] No

Do I have permission to contact your primary care physician if necessary? [ ] Yes [ ] No

Have you ever used:	No	Yes	When?	How much?	How often?
Cigarettes?					
Alcohol?					
Recreational drugs? Which?					

Have you ever been in treatment for substance abuse? [ ] No [ ] Yes, Date(s) _____

Family history of mental illness or substance abuse: _____

Have you ever been treated by a psychiatrist? [ ] No [ ] Yes, Date(s) _____

Previous psychiatric hospitalizations? [ ] No [ ] Yes, Date(s) _____

Place _____Reason_____

Are you currently being treated by a psychiatrist? [ ] No [ ] Yes

Psychiatrist _____ Phone_____

Do I have permission to contact your psychiatrist? [ ] No [ ] Yes

Previous counseling? [ ] No [ ] Yes, Date(s) _____ Reason _____

Was it helpful? [ ] No [ ] Yes

What do you consider to be your strengths? _____

What do you enjoy doing in your leisure time? _____

_____

Signature ***Date***