MEDICAL HEALTH HISTORY

Primary Care Physician:_____ Telephone:_(____)_____

Address:_____

	YES	NO
1. Have you had any past health problems, hospitalizations or surgeries?	☐	☐
If Yes, please explain:		
2. Do you have any known present health problems?	☐	☐
If Yes, please explain:		
3. Are you currently taking any medications?	☐	☐
If Yes, please list the medications you are presently taking:		

4. Name(s) of doctor(s) presently treating you: _____

5. What faith do you practice? (0ptional)_____

6.. Have you ever received counseling? ☐ ☐

If Yes, please give the name of your Counselor and dates of service:

7.. Are you experiencing any of the following symptoms:

☐ Anxiety	☐ Aggressive Behavior	☐ Dizziness, light-headedness
☐ Depression	☐ Assaultive Behavior	☐ Hallucinations: [ ] Auditory [ ] Visual
☐ Sleep Problems	☐ Conduct Disorder	☐ Paranoia
☐ Weight Change	☐ Attention Problems	☐ Substance Use/Abuse
☐ Isolation	☐ Concentration Difficulty	☐ Eating Disorder or Difficulties
☐ Obsessive/Compulsive	☐ Confusion	☐ Other:_____

8. Frequency of: Alcohol_____ Drugs_____

9. When did the problems begin and why did you choose to seek help?

Referred by:_____ Phone:_____