Comprehensive Counseling Center
Medical History

IDENTIFYING INFORMATION

Patient Name_____Referred by:_____

MEDICAL INFORMATION

1.Family Doctor (PCF)_____Phone Number_____

2. Has there been any changes in your health since your last appointment?
Yes ___ No___
If yes, please describe:

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3. Are you taking any medications, including over-the-counter medications?
Yes___ No___
If yes, please specify name or kind (include birth control)

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4. Do you have any medication allergies? Yes___ No___
If yes, please list the medications:

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5. Do you have any other problems now with your health? (e.g. digestive problems, chronic pain?) Yes___ No___
If yes, please specify

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6. Have you ever been in the hospital overnight? Yes___ No___
If yes, list when and why:

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7. Do you now or have you ever had any of the following? (Check all that apply)

___Unusual Habits	___Hearing problems
___Nervousness/panic	___Problems with vision
___Asthma or respiratory condition	___Memory problems
___Seizures or convulsions	___Hallucinations
___Anemia	___Problems with rage, violence
___Heart condition	___Attention problems
___High blood pressure	___Metabolic problems
___Lead poisoning	___Substance use
___Chronic headache	___Caffeine use
___Diabetes	___Tobacco use

___Arthritis
___Bleeding problems
___Any operations or surgery
___Unusual Thoughts
___Excessive fantasies
___Difficulty relating to people
___Sleep problems
___Significant physical trauma or injury
___Tiredness/weakness
___Inherited disease
___Obsessions
___Bizarre or strange behavior
___Tics
___Eating problems

8. Please check those illnesses, which have been present in family members. Also, please list the family member

___Allergies
___Asthma
___Diabetes
___Heart problem
___Metabolic problems (thyroid)
___Depression
___Seizures
___Neurological problem
___High blood pressure
___Schizophrenia
___Eating problems (anorexia/bulimia)
___Obsessive-compulsive disorder

FUNCTIONING (Please rate how your problem(s) or emotional status currently functioning in the following areas.)

	None	Mild	Moderate	Severe
Family relations	___	___	___	___
Work/school performance	___	___	___	___
Social relations	___	___	___	___

SUBJECTIVE DISTRESS (Please rate the current degree of distress you experience due to your problems or emotional status.)

	None	Mild	Moderate	Severe
Depression	___	___	___	___
Anxiety	___	___	___	___

Other_____

_____ _____
Signature of patient Date