

Health Care Providers (currently receiving care or seen within the last year)

Family Physician _____ Phone _____
date of last physical _____
Psychiatrist _____ Phone _____
Other _____ Phone _____
_____ Phone _____
_____ Phone _____

Current Medications

Please list all of the medications you are taking. Include over the counter medications, herbs, & vitamins

Medication Name	Dose	Last taken	First taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical history

Please check if you have ever been diagnosed or received treatment for any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anorexia or bulimia | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Stroke or Cerebrovascular Accident |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Personality Disorder | |

Please describe any of your current health problems, chronic health conditions or allergies.

Please check any of the following symptoms you have experienced within the last 6 months

- | | | |
|--|---|--|
| <input type="checkbox"/> Weight loss or gain | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Fear of people, places, or things |
| <input type="checkbox"/> Sadness lasting for days or weeks | <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Difficulty falling asleep, staying asleep | <input type="checkbox"/> Thoughts of hurting yourself | |

Have you ever been involved in treatment before? Yes No

If so please describe _____

Have you ever been hospitalized or participated in residential treatment for emotional, behavioral, or mental health concerns. If yes, please describe. Yes No

Family History: Describe all medical conditions in your immediate family

