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Medical and Social History Form

Name _____ Date of Birth_____

Address _____

Phone number _____

Cell Phone _____

Physician /Other Health Care Provider:

Physician _____ Phone _____

Address _____ City _____

Specialist _____ Phone _____

Address _____ City _____

Psychotherapist / Psychiatrist / Nurse Practitioner

Psychotherapist _____ Phone _____

Address _____ City _____

Psychiatrist/ NP _____ Phone _____

Address _____ City _____

Marital Status:

□ Single □ Married □ Divorced □ Widowed

Education: Please check highest level achieved

□ Grade School □ Jr. High School □ High School

□ College (2-4 years) □ Graduate School □ Degree _____

Are you employed? □ Yes □ No □ Part Time □ Full Time □ Retired

Employer: _____

Student in School? □ Yes □ No □ Part Time □ Full Time

Name of School _____

List any prescription medications you are now taking: _____

_____

_____

List dietary supplements or vitamins you take: _____

_____

_____

Do you drink? □ Yes □ No

Do you smoke? □ Yes □ No

Do you use recreational drugs? □ Yes □ No

Date of last complete physical examination: _____

□ Normal □ Abnormal □ Never □ Can't remember

Date of last dental check up: _____

□ Normal □ Abnormal □ Never □ Can't remember

List any drug, food or substance allergies: _____

_____

_____

List dates of hospitalizations, surgeries or accidents: _____

_____

_____

Past Medical History

Have you personally experienced any of the following?
(Check those to which the answer is yes, leave others blank)

- □ Heart Attack if so, when _____
- □ Chronic Fatigue Syndrome
- □ Epstein Barr
- □ Fibromyalgia
- □ Arthritis
- □ Alzheimer's or dementia
- □ Diabetes
- □ Lyme's Disease
- □ Dizziness or fainting spells
- □ Epilepsy or seizures
- □ Stroke
- □ Anemia
- □ Thyroid problems
- □ Asthma
- □ Colitis, GERD or other digestive issues
- □ Loss of time or memory issues
- □ Difficulty walking

Family Medical History

Father: □ Alive Current age _____ My father's general health is:

□ Excellent □ Good □ Fair □ Poor

□ Deceased □ Age at death _____

Mother: □ Alive Current age _____ My mother's general health is:

□ Excellent □ Good □ Fair □ Poor

□ Deceased □ Age at death _____

Siblings: Number of brothers _____ Number of sisters _____

Familial Illness History

Have you or any blood relatives experienced any of the following?
(Check those to which the answer is yes, leave others blank)

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Panic or anxiety
- ☐ Dementia
- ☐ Obsessive or compulsive behaviors
- ☐ Sleeping difficulties
- ☐ Eating difficulties
- ☐ Memory problems
- ☐ Schizophrenia
- ☐ Post Traumatic Stress Disorder
- ☐ Attention Deficit Disorders
- ☐ Addiction: Alcohol, Drugs, Gambling, Internet
- ☐ Bulimia or Anorexia
- ☐ Social Anxiety
- ☐ Learning disabilities

Please list any other information you would like me to know: _____

_____

_____

What are your goals for psychotherapy treatment? _____

_____

_____