MEDICAL & PSYCHOLOGICAL HISTORY

Today's date:_____

Patient name _____ _____

(Print) Last First M.I. Age

Please list all medications including over the counter (vitamins, supplements)

Medication	Dose	Frequency	Reason

Please list all existing and past medical and psychological conditions:

Existing conditions	Treatment/surgery

Previous conditions	Treatment/surgery

Family medical and psychological history (relationship and condition)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please check off any symptoms you are currently experiencing:

☐ Anxiety
☐ Depression
☐ Hallucinations
☐ Loss of interest
☐ Sleep changes/difficulties
☐ Phobias
☐ Appetite issues
☐ Excessive energy
☐ Impulsivity
☐ Panic attacks
☐ Suspiciousness
☐ Difficulty concentrating
☐ Avoidance of certain situations
☐ Fatigue
☐ Irritability
☐ Racing thoughts
☐ Body image concerns
☐ Crying spells
☐ Guilt
☐ Libido changes
☐ Risky activities
☐ Self-harming (cutting/burning, etc)

Are you currently experiencing the following?

Suicidal ideation ☐ Yes ☐ No
Homicidal ideation ☐ Yes ☐ No

Have you attempted suicide in the past? ☐ Yes ☐ No

Has anyone in your family attempted/completed suicide in the past? ☐ Yes ☐ No

What is your primary reason for starting therapy?

What social supports do you have currently? (Friends/family/religious groups, etc.)