



Patient Medical Information

Patient Name: _____ Therapist: _____ Date: _____

Name of Primary Care Physician (PCP): _____ Phone: () _____

Release – I authorize release of information to my PCP (circle one): Y or N Initials ___ Date ___

Check any of the following that have been problematic over the last 6 months:

- Alcohol Abuse, Allergies to Food or Medications, Amnesia/Blackouts, Anger Problems, Anxiety, Bowel, Cancer, Concentration Problems, Depression, Diabetes, Dizziness/Fainting, Eating Problems, Educational Problems, Epilepsy, Excessive Energy, Excessive Worrying, Extreme Fears, Fatigue, Financial Problems, Gay/Lesbian Issues, Headaches, Heart, High Blood Pressure, Lack of Energy, Lack of Motivation, Lack of Self-Control, Legal Problems, Loneliness, Loss of Family Member, Marital Problems, Memory Problems, Muscle/Joint, Nightmares, Overtiredness, Panic Attacks, Physical Assault, Problems with Children, Separation/Divorce, Sexual Assault, Sexual Problems, Shyness, Sleep Problems, Stomach, Substance Abuse, Suicidal Thoughts, Ulcer, Unhappiness, Weight, Work/Career Problems

Other (list all conditions not mentioned above) _____

Major illnesses/surgeries/injuries/hospitalizations (incident and date(s)): _____

Previous counseling/psychiatric services (list diagnosis and date(s)): _____

Current medications (list medication name, prescribing physician and dosage): _____

Who/how were you referred to our practice? _____

Have any family members participated in counseling? (Check all that apply):

Mother ___ Father ___ Sisters ___ Brothers ___ Grandparents ___ Spouse ___ Children ___

Reason for seeking help at this time: _____