Medical History

What concerns bring you in today?

_____

_____

Symptoms (Check all that apply)

	I have this now	I've had this in the past
Depressed mood		
Low self esteem		
Worry, nervous		
Low energy		
Lack of interest		
Change in appetite		
Weight loss/gain		
Change in sleep pattern		
Change in sex drive		
Feel something is wrong with my body		
I feel like hurting myself		
I feel like hurting others		
Relationship conflicts/tension		
Drug/alcohol use		

If drug/alcohol use is checked, please describe:

_____

_____

_____

Brief medical history

Name of doctor _____

Medications Prescribing doctor Reason prescribed

_____

_____

_____

Previous mental health treatment

Therapist name Date Reason

_____

_____

_____

Hospitalizations (medical, psychiatric, chemical dependency)

Hospital Reason Date

_____

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