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Medical History Form

Name:____**Date:**____________________

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

Have you been in therapy before? _________

Do you experience hallucinations? _________

Have you been convicted of a crime? _________

Do you experience suicidal thoughts? _________ If yes, please explain:

Do you or a family member have a known mental illness?_________ If yes, please explain:

Do you have any medical problems?__________ If yes, please explain:

❑ Abuse ❑ Aggression, violence ❑ Alcohol use ❑ Anger/ hostility ❑ Anxiety ❑ Career concerns ❑ Childhood issues ❑ Compulsions ❑ Delusions ❑ Depression, sadness ❑ Divorce, separation ❑ Drug use- prescription, over the counter, street drugs ❑ Eating disorders ❑ Emptiness ❑ Failure ❑ Fatigue ❑ Grieving, mourning, deaths ❑ Guilt ❑ Headaches, migraines	❑ Hallucinations ❑ Health, illness, medical concerns ❑ Inferiority, interpersonal conflicts ❑ Impulsiveness ❑ Irresponsibility ❑ Loneliness ❑ Marital, relationship problems ❑ Mood swings ❑ Nervousness ❑ Pain ❑ Temper problems, self-control ❑ Thought disorganization, confusion ❑ Threats, violence ❑ Fears, phobias ❑ Financial troubles ❑ Gambling	❑ Panic or anxiety ❑ Parenting, child management ❑ Pessimism ❑ Procrastination ❑ Self-esteem, self-neglect ❑ Sleep problems- insomnia, nightmares ❑ Smoking ❑ Spiritual, ethical issues ❑ Stress ❑ Suicidal thoughts ❑ Weight and diet issues ❑ Work problems