

HOUSEHOLD COMPOSITION:

NAME ;	BIRTHDATE :	RELATIONSHIP :
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. MEDICAL-PSYCHIATRIC HISTORY

FAMILY PHYSICIAN _____ Last Contact :

HEIGHT : _____ WEIGHT : _____ USUAL WEIGHT : _____

(If you have not had a physical in the last year, I highly recommend you schedule one.)

PREVIOUS COUNSELLING : Yes _____ No _____ LAST COUNSELLOR AND DATES:

OTHER COUNSELORS , ADDRESSES AND DATES:

Did you consider these contacts successful? _____ Why?

PREVIOUS PSYCHIATRIC HOSPITALIZATION : Yes _____ No _____ Where:

Dates: _____ Presenting Problem: _____

FAMILY HISTORY OF EMOTIONAL PROBLEMS : Yes _____ No _____ What members and nature of problems:

CURRENT MEDICATIONS (of any type) : Yes _____ No _____ List each:

PERSCRIBING PHYSICIAN (with phone number) FOR CURRENT MEDS:

PAST PSYCHIATRIC MEDICATIONS' : Yes _____ No _____ Describe effectiveness :

CURRENT MEDICAL PROBLEMS : Yes _____ No _____ Describe :

PAST MEDICAL PROBLEMS : Yes _____ No _____ Describe:

DESCRIBE DRUG/ALCOHOL USE:

D. PRIMARY CONCERN AND WHEN DID YOU FIRST BECOME AWARE OF THE PROBLEM:

REFERRAL SOURCE :

EMERGENCY CONTACT/ PHONE
NUMBER: _____