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PATIENT TREATMNET & MEDICAL HISTORY

Name _____ Date of Birth _____ /_____ /_____

GOALS FOR TREATMENT

What concerns do you want to work on?_____

_____

_____

What are your goals for treatment?_____

_____

MEDICAL HISTORY

Date of last physical exam_____ /_____ /_____

Significant findings_____

_____

Current prescription and/or over the counter medication (dosage, frequency & prescribing doctor)_____

_____

_____

Medication allergies_____

_____

Current & previous medical illnesses_____

_____

_____

Hospitalizations (include hospital names/dates/procedures/diagnosis)_____

_____

_____

FAMILY HISTORY

Does anyone in your immediate family have a history of serious illness? If yes, explain_____

_____

_____

Please list any medical, psychological or chemical dependency family history, including suicide or homicide attempts_____

_____

_____

Describe any abuse/trauma to yourself or any person in your family_____

_____

_____

Have you been accused of/investigated for/charged with committing child abuse/elder abuse/domestic violence_____

_____

_____

PREVIOUS PSYCH/CHEMICAL DEPENDENCY TREATMENT

Chemical use/abuse history (if not applicable, please mark here ____)

Substance	Current or Past	Amount/Frequency	Time Period Used	Date Last Used
Alcohol				
Marijuana				
Speed				
Cocaine				
Prescription Drugs				
Other: _____				

Please list **previous therapists and/or programs**, reasons for treatment, type of treatment and dates (separate Releases of Information will be required)_____

_____

_____

_____

Legal problems/arrests/lawsuits (civil and or criminal)_____

_____

_____

Any other information that may be useful in treatment_____

_____

_____

_____

_____

_____