Medical / Psychotherapy History

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Provider Information

	Name	Address	Phone #	Date of Last Visit
1. Physician				
2. Psychotherapist				
3. Psychiatrist				
4. _____				

Medical History

Date of Last physical/ medical exam: _____

Do you smoke: Yes / No Frequency _____

Alcohol Consumption: NA Rarely Weekly Daily

Current Medications:

1. _____ Dosage: _____ For_____
   Frequency_____
2. _____ Dosage: _____ For_____
   Frequency_____
3. _____ Dosage: _____ For_____
   Frequency_____
4. _____ Dosage: _____ For_____
   Frequency_____
5.

List Medical Issues

1. _____
2. _____
3. _____
4. _____

Hospitalizations:

	When	Where	Length
___Substance Abuse			
___Alcoholism			
___Eating Disorder			
___Psychiatric Disorder			

Psychotherapy History

	Therapist	Purpose of Visit	When	Where	Length
1.					
2.					

Family History

Were you raised by : Both Parents Single Parent Relative Other

Fathers Name: _____ Living
Deceased _____Age

Mothers Name _____ Living
Deceased _____Age

Family History: ___Alcoholism ___Substance Abuse ___Mental Illness ___Prolonged Illness

Emergency Contact:

Name:_____Relationship:_____
Preferably a person who does not live with you

Address_____

Phones: Home:(____)_____ Work: (_____)_____ Cell: (_____)_____

Family and Other Individuals Who May Expected to Be Involved in Treatment:*
Please list all family members, spouse or significant other(s), friends, other providers, or other individuals that you foresee that you wish to authorize disclosure of healthcare information with:

_____
_____
_____

[*Note: Psychotherapy notes may only be disclosed with a specific client authorization except when used by the provider for therapy or in order to defend against a legal action or other proceeding instituted by the client.]

My signature indicates that I have read this document and been given an opportunity to ask questions. I understand and accept the conditions..

Statement of Acknowledgment: **"I have read and understood the above."**

Client Signature:_____
Date:_____