Medical History Questionnaire

Bari Isaacson, L.P.C.

Client's Name: _____Date of Birth: ____/_____/_____

This information will help me to help you; however if you are uncomfortable answering any of the questions, please feel free to leave them blank and we will discuss them in the first session.

All information is confidential

PROBLEM CHECKLIST: Check ( ) every item you have had.
Circle ( ) those problems which you consider serious and still trouble you.

__ Alcohol Abuse
__ Allergies food or environmental
List_____
__ Anger/Agitation
__Appetite change
__Anxiety
__Attention/Concentration difficulties
__Blood Pressure
__Decision making problems
__Depression
__Diabetes
__Divorce or separation
__Drug Use
__Eating disorder type_____
__Euphoric (high) mood swings
__Family Problems
__Fatigue/ low energy
__Financial problems
__Gambling
__Grief
__Guilt
__Hallucinations/hearing voices
__Headaches chronic
__Head Injury
__Heart Problems
__Hepatitis
__HIV
__Hypoglycemia
__Irritability
__IV drug use
__Memory problems
__Mood swings
__Obsessions
__Panic
__Phobias type_____
__Recent weight change
__Rituals (counting/checking)
__Sexual problems
__Self harm/mutilation
__Social isolation
__Sleep disturbance/nightmares
__Stomach problems
__Suicidal feelings
__Suicidal attempts
__Thyroid problems
__Trauma survivor
physical/emotional/sexual
__Ulcers
__Worry chronic

Other_____

Family & Interpersonal History

List others living in the home:

Name	Age	Relationship to Client

Overall Rating

Rate your **physical health** on a scale of 1 to 10 (1=very poor health, 10= excellent health) _____
Rate your current **psychological distress** (1=very low, 10=extreme distress) _____

Medical Information

Medical Care Provider (Physician or Other) _____
If you are under medical care at this time, explain the reason_____

List **any medication**(s) you are presently taking, prescribed or otherwise:

	Medicine	Dosage	Prescribed by	Reason for Taking
1.				
2.				
3.				
4.				
5.				

Surgeries/Injuries/Major Illnesses	Your Age or Year Occurred
1.	
2.	
3.	
4.	

Nutrition: Good___ Fair___ Poor____ **Appetite**: Good___ Fair____ Poor____

Sleep Pattern (check all that apply)

No Problem__ Problems falling asleep__ Early wakening__ Frequent wakening__
Non-restful___ Too much sleep___ Too little sleep___ Disturbing dreams___

****Women Only**: (check all that apply)

Pregnant or unsure___ Breast-Feeding___ Birth Control Method_____
If Premenstrual problems rate by circling: mild moderate severe
If Menopausal symptoms, rate by circling: mild moderate severe

Counseling/Treatment History

If you have you ever seen a psychologist, psychiatrist, social worker or counselor, fill out below

	When	Who	Problem	Date(s)/ Length of Treatment
1.				
2.				
3.				
4.				

If any member of your immediate/birth family has mental health problems, list:

	Who	Problem Area(s)
1.		
2.		
3.		
4.		

Were you ever assessed as having any of the following:
__Dyslexia __IEP (Individualized Education Plan) __504 Plan ___Remedial Classes

Legal Involvment

Have you ever been arrested, accused or convicted of a crime?
If Yes, describe:

Are you currently involved in the legal/court system? If so, why?

Have you legal representation? Who?

Education Highest grade completed for self_____ partner _____
Special training for self_____ partner_____

Employment Occupation for self_____Employer_____

Occupation for partner_____ Employer_____

Substance Use **no alcohol past 6 months___** **no street drugs past 6 months___**
Type of use: Beer__ Wine___ Mixed drinks___ Coolers___ Straight Drinks___
How often do you drink_____ How much when you drink_____
Last time you drank to excess/were drunk?_____
Has your spouse or family every been concerned about your drinking/drug use? _____

Have you ever been cited or arrested for driving under the influence? _____ When_____
Have you ever been in Diversion or a treatment program for alcohol or drug use
When?_____ Where?_____

At what age(s) have you used street drugs_____ never_____
Type of drug(s) when using:

Personal Habits If you smoke cigarettes, how much_____For how long_____
If you chew tobacco, how much_____ For how long_____
If you use caffeinated beverages on a daily/regular basis,
Type_____ How much_____
Type_____ How much_____

Life Experiences

If you have served in the military, which branch_____
Combat?_____ Dates of service_____
Where stationed_____ Type of discharge_____

Have you ever been pushed, slapped, choked, bruised in a relationship? _____
If yes, has this happened within the past 3 months? _____

Has anyone ever touched, fondled or in any other way been sexually inappropriate with you? ___

If you have experienced a traumatic life threatening injury or event, describe briefly
_____
_____
_____

Current Problem – *Describe briefly why you are seeking counseling*

_____
_____
_____
_____