Name: _____ **DOB**: _____

Medical History Questionnaire

Please check any problems that you, or your family, have experienced.

	Self	Family Member	Extended Family History
Depression	☐	☐	☐
Diabetes	☐	☐	☐
Cancer	☐	☐	☐
Alcoholism	☐	☐	☐
Drug Addiction	☐	☐	☐
Learning Problems	☐	☐	☐
Seizures	☐	☐	☐
Anxiety	☐	☐	☐
Psychosis (Hallucinations)	☐	☐	☐
Chronic pain	☐	☐	☐
Manic Depression (Bipolar Illness)	☐	☐	☐
Thyroid Problems	☐	☐	☐
High Blood Pressure	☐	☐	☐
Migraine Headaches	☐	☐	☐
Fainting	☐	☐	☐
Chronic Fatigue	☐	☐	☐
Tumors	☐	☐	☐
Ulcers	☐	☐	☐
Sexual Problems	☐	☐	☐
Paralysis	☐	☐	☐
Amnesia	☐	☐	☐
Obesity	☐	☐	☐
Insomnia	☐	☐	☐

	Self	Family Member	Extended Family History
Heart Trouble	☐	☐	☐
Heavy Smoking	☐	☐	☐
Neurological Disease	☐	☐	☐
Lupus	☐	☐	☐
Liver Problems	☐	☐	☐
HIV	☐	☐	☐
Ringing in Ears	☐	☐	☐
Pounding Heart	☐	☐	☐
Asthma	☐	☐	☐

Other: _____

Have you ever been hospitalized? Yes No Reason: _____

Are you currently taking any medications? If so, please list: _____

_____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much? _____

How much coffee, tea or soda do you drink a day? _____

Have there been any deaths in your family in the last 5 years? Yes No Whom? _____

Any family history of physical abuse? Yes No By whom, to whom: _____

_____

Any family history of sexual abuse? Yes No By whom, to whom: _____

_____

Have you had any previous counseling? Yes No Name of counselor: _____

Last Date of Service:

_____

Do you have any disabilities that we should know about: _____

_____

I understand that I am responsible for attending to my own medical conditions and following up on recommendations made by the therapist. This information is true to the best of my knowledge.

Client Signature: _____ Date: _____