

Medical History Form

Directions: Please answer the following questions to the best of your knowledge. Complete both the front and back of this form.

Patient Information			
Last Name	First Name	MI	Birthdate
Children: <input type="checkbox"/> Yes <input type="checkbox"/> No How many?		Number of persons living in your home?	
Primary Therapist (s) or Physician(s)			
Name:	Name:	Name:	
Address:	Address:	Address:	
Phone:	Phone:	Phone:	

Are you allergic to any medications? Yes No If yes, what medication (s)? _____
 Are you allergic to any substances or foods? Yes No If yes, what substance (s)? _____

Family History	Please <input checked="" type="checkbox"/> if your family has a history of:
<input type="checkbox"/> Diabetes <input type="checkbox"/> Mental Illness <input type="checkbox"/> Epilepsy/Seizure <input type="checkbox"/> Cancer <input type="checkbox"/> Alzheimer's <input type="checkbox"/> History Unknown	

Any other neuropsychological or psychiatric conditions? _____

If you answered "Yes" to any of the above, please explain: _____

Are you currently being treated for any medical conditions? Yes No If yes, please list: _____

Medications (List more on separate page if necessary)					
Current Medication	For what condition?	Dosage	Frequency	Date Started	Comments/Problems/Concerns

Past Medications/For what condition? (List sedatives, pain medications, sleeping pills, antidepressants, etc.)

Social /Sexual Risk History	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke? If yes, how many cigarettes per day?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use alcohol? If yes, how often, how much?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)

