PERSONAL AND MEDICAL DATA FORM (Adult)

Name _____ Today's date _____

Date of birth _____ Age _____ Gender _____ Ethnicity _____

Specific reason for today's visit _____

Do you have any of the following concerns?

____ Anxiety/ panic/OCD ____ Sleeping problems ____ Alcohol / drug problems

____ Depression ____ Dramatic mood swings ____ Anger problems

____ Suicidal thoughts ____ Problems focusing ____ Problems functioning

____ Eating concerns (i.e. anorexia/ bulimia) ____ Experiencing "unreal" thoughts or having hallucinations

Are you currently taking any psychiatric medication? If yes, please list each med and the dosage:

_____

_____

Have you ever had a bad reaction to a psychiatric medication? If yes, please describe:_____

_____

Any history of: ____ Psychiatric hospitalization ____ Suicide attempt ____ Alcohol/ drug rehabilitation

MEDICAL CONCERNS:

Height: _____ Weight: _____

Indicate which of the following you have experienced or are currently experiencing:

____ Heart problems ____ High blood pressure ____ Seizure ____ Major head injury

____ Thyroid problems ____ Stomach problems ____ Diabetes ____ Asthma

____ Menstrual problems ____ Currently pregnant or breast-feeding

Other Medical Concerns: _____

_____

_____

Are you allergic to any medication? (if yes, please list) _____

Are you taking any medical medications/ herbal/ over the counter medications on a regular basis? If yes, please list each med and the dosage: _____

_____

_____

_____

_____

MEDICAL CARE:

Do you have a regular healthcare provider (i.e. PCP)? _____ Last visit: _____

Last time you had your blood drawn? _____ Results: _____