

Medical and Health History

Name: _____ Date: _____

List any allergies: _____ None _____

Primary Care Physician: _____ Address: _____

City: _____ State: _____ ZIP: _____

Primary Care Physician's phone number: (____) _____

Date of most recent physical examination: _____

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	Starting Date

Please list all current or past health problems, and any major operations:

Current	Past

Have you been in counseling before? Yes _____ No _____ Was it helpful Yes No

If No, please explain: _____

List all therapists you have seen, reason for seeking help and dates of treatment:

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:

Have you ever experimented with or used alcohol or other drugs? Yes ___ No ___

Please provide your age when you first used and how many times you have used I the past 30 days:

Substance Used	Age Started	How often? Past 30 days
Cigarettes or chewing tobacco		
Alcohol Alcohol to point of intoxication (drunk)		
Marijuana		
Cocaine/Crack		
Amphetamines		
LSD		
Heroin or Opium		
Ecstasy Baarbiturates Methadone Opiates (codeine,morphine, percocet) Inhalants Polydrug use Others (please list):		

Have you ever used a needle to shoot any of these drugs? Yes ___ No ___

Do you worry about how substance use may affect your future or health? Yes No

What kind of problem(s) brings you to Naugle Counseling Services?

Please indicate if you are having any of the following problems, or if you had them in the past:

	Currently	Past
<u>Difficulty falling asleep or staying asleep</u>	<u> </u>	<u> </u>
<u>Sleeping too much</u>	<u> </u>	<u> </u>
<u>Change in appetite, weight loss, or weight gain</u>	<u> </u>	<u> </u>
<u>Frequent crying</u>	<u> </u>	<u> </u>
<u>Panic attacks or anxiety attacks</u>	<u> </u>	<u> </u>
<u>Thoughts of killing or hurting myself</u>	<u> </u>	<u> </u>
<u>Attempts to kill or hurt myself</u>	<u> </u>	<u> </u>
<u>Problems concentrating</u>	<u> </u>	<u> </u>
<u>Problems remembering things</u>	<u> </u>	<u> </u>
<u>Periods of daily sadness lasting more than two weeks</u>	<u> </u>	<u> </u>
<u>I startle easily</u>	<u> </u>	<u> </u>
<u>Can't stop remembering upsetting past events</u>	<u> </u>	<u> </u>
<u>Difficulty controlling my temper</u>	<u> </u>	<u> </u>
<u>I physically hurt other people</u>	<u> </u>	<u> </u>
<u>I break things sometimes</u>	<u> </u>	<u> </u>
<u>I worry a lot</u>	<u> </u>	<u> </u>
<u>Little or no interest in sex</u>	<u> </u>	<u> </u>
<u>I feel tired almost every day</u>	<u> </u>	<u> </u>
<u>Feelings of unreality</u>	<u> </u>	<u> </u>
<u>Made myself throw up in order to lose weight</u>	<u> </u>	<u> </u>
<u>Used laxatives or exercised excessively to lose weight</u>	<u> </u>	<u> </u>
<u>I often feel like I am an outsider</u>	<u> </u>	<u> </u>
<u>Sexual problems</u>	<u> </u>	<u> </u>
<u>Worry that something is wrong with my body</u>	<u> </u>	<u> </u>
<u>Frequent arguments with the people I live with</u>	<u> </u>	<u> </u>
<u>I hear voices inside my head</u>	<u> </u>	<u> </u>
<u>Other (please list):</u>	<u> </u>	<u> </u>

Signature Date

Signature of Parent/Guardian (if child is under age 14) Date