INNER DAWN LLC
NICHOLE BELLFY, LMSW - PSYCHOTHERAPIST

MEDICAL HISTORY RECORD

Name: _____ Date:_____

Please list any physical illnesses, diseases, or serious accidents you have had in your life, especially those which required hospitalization.

_____ Age:_____

_____ Age:_____

When did you last have a physical exam:_____

How would you rate your present physical condition? ❒ Excellent ❒ Good ❒ Poor

Check any of the following physical conditions that apply to you:

❒ Thyroid Problems
❒ Diabetes Mellitus
❒ High Blood Pressure
❒ Multiple Sclerosis (MS)
❒ Stomach Ulcers
❒ Menstrual Irregularities
❒ Chest Pain
❒ Ulcerative Colitis
❒ Migraine Headaches
❒ Other_____

List any allergies, drus sensitivities, physical handicaps, or seizure activities you may have:

_____

_____

Are you presently taking any medication and/or drugs? ❒ Yes ❒ No

Name of Drug Dosage Frequency

_____

_____

_____

Physician's Name: _____

Address:_____ Phone:_____

Mental Health Clinic Information

Medication Prescribed by Medical Doctor:

Date Medication Dosage Frequency Number of Pills Prescribed Phone

_____

_____

Previous Mental Health Services/Previous Counseling:

Date From:_____ To:_____ Organization/Agency/Therapist:

_____