Ponderosa Counseling

Medical History Questionnaire

Name: _____ Date: _____

Allergies: _____

Medical History

Yes	No	*Please Check Yes or No for Each Item Listed*	*If Yes, Furnish Details Including Dates*
		1. During the **past** have you: A. Been treated for any medical condition?	
		B. Been hospitalized?	
		C. Had an X-ray, electrocardiogram, or laboratory test?	
		D. Had surgery?	
		2. Has anyone in your immediate family (parents, grandparents, siblings) had a neurological or cardiac illness? Sudden death?	
		3. Has anyone in your immediate family had or been treated for an emotional problem or mental illness?	
		4. Do you drink coffee/tea/soda? If yes, how much?	
		5. Do you smoke cigarettes? If yes, how much?	
		6. Do you drink alcohol? If yes, how much?	
		7. Do you smoke/ingest marijuana? If yes, how much?	
		8. Have you ever taken: A. Cocaine, amphetamine, methamphetamine?	
		B. Heroin?	
		C. Morphine, Vicodin, oxycodone, Percocet?	
		D. Other drugs?	

Date of last physical: _____ Results/recommendations: _____

List all current medication and dosages: _____

_____

List all current supplements and dosages: _____

_____

Have you ever had a neurological evaluation (exam, MRI, CAT scan, EEG, etc.)? If yes, describe: _____

_____

Have you received counseling, psychiatric, or psychological evaluation or treatment? If yes, list:

Date	Reason	Provider	Phone
_____	_____	_____	_____
_____	_____	_____	_____

Review of Symptoms

Have you ever had, or have been told you have had the following? (If "have now" and "had in past", check Yes)

Yes	No	*Check One for Each Symptom*	Yes	No	*Check One for Each Symptom*
		Severe headaches, migraines			Stomach problems or acid reflux
		Dizziness or fainting spells			Recent gain/loss of weight (circle gain or loss)
		Seizures or epilepsy			Diabetes
		Concussion or head injury			Thyroid trouble
		Stroke			Anemia
		Eye problems			Jaundice or liver disease
		Hearing problems			Urinary accidents, bedwetting
		Movement problems			Kidney disease
		Skin problems			Genetic disorder
		Asthma or shortness of breath			Developmental delays, learning disabilities
		Palpitations, heart problems			MALES – Sexual dysfunction
		High blood pressure/low blood pressure			FEMALES – Pregnancy, menstrual problems, sexual dysfunction

Please list any other disease or condition you may have that is not listed above:

_____

_____

_____

_____ _____

Client's Signature OR Parent/Legal Guardian if Client is Under Age 15 Date

_____ _____

Reviewed By Date