Health History

Name:_____

Known Allergies:_____

Psychiatrist or treating Doctor:_____

Current Medications:

	Medicine Dose	Times/day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently use any of the following? Caffeine: Coffee: amount/day:_____

Tea: amount/day:_____ Soft drinks: amount/day_____

Alcohol: Beer: amount_____ per (circle one) day, week, month

Mixed drinks/neat (amount in ounces of alcohol) _____ per day, week, month

Drugs: Marijuana amount _____ per (circle one) day, week, month

Stimulants: Cocaine, Methamphetamine, etc. amount_____ per day, week, month

Other drugs: List type, frequency, and amount _____

Have you ever received treatment for addictions? When/Where_____

Cigarettes, cigars, chew tobacco, snuff amount _____ per day, week, month

Do you have any of the following? Please check.

____ Diabetes ____ Heart problems:

____ Asthma ____ Thyroid:

____ Depression ____ Addictions:

____ Bipolar ____ Learning disabilities

Check any of the symptoms below…

_____ Headaches, neck pain

_____ Back pain

_____ Shortness of breath/pressure in chest

_____ Pounding heart/fluttering

_____ Recent gain/loss of weight

_____ Epilepsy/seizures

_____ Vision problems

_____ Indigestion/bowel problems

_____ Memory loss/ increased forgetfulness

_____ Anxiety attacks/nervousness

_____ Skin problems

_____ Worrying/obsessing

_____ Anger/rages

_____ Phobias, fears

_____ OB/GYN problems

_____ Fatigue/more tired

_____ Eating problems (restricting, overeating)

Head injuries:

Falls, accidents where you hit your head: Concussions, closed head injuries, head injuries

Did you ever play football or other contact sports?

Have you ever lost consciousness?

Used any inhalants, exposed to toxic materials?

Hospitalizations/surgeries:

Age: _____ Reason_____

Age_____ Reason_____