

Name: _____ Birth date: _____

General Medical Information

Please circle any of the following symptoms/problems that pertain to today's visit:

Nervousness	Depression	Fears/Phobias	Suicidal Thoughts
Shyness	Sexual Concerns	Separation/Divorce	Weight
Having to do over & over	Coping w/a traumatic event	Thought I can't get out of my mind	Need to be in control of everything
Finances	Alcohol/Drug use	Career choices	Friends
My Past	Stomach Troubles	Dependency	Relationship Problems
Anger/Temper	Self-Control	Unhappiness	Sleep
Tiredness	Legal Matters	Memory	Lack of Ambition
Procrastination	Education	Inferiority Feelings	Concentration
Unresolved Grief	Loss of Control	Health Problems	Nightmares
Marriage	Work	Appetite	Blocked Emotions
Being a Parent	Forgetfulness	Up-and-down Feelings	Relaxation

Other: _____

Current Medications: _____

Allergies to Medications: _____

Allergies: _____

Other Physicians Currently Treating You:

Name: _____ Phone #: _____

Reason: _____

Name: _____ Phone #: _____

Reason: _____

Previous or Other Medical Problems: _____

List of any surgeries and/or non-psychiatric hospitalizations (type of surgery, approximate date, and what hospital or doctor): _____

List of Psychiatric Treatment or Hospitalizations: _____

Family Psychiatric History (if known): _____

Pharmacy: _____