

Sonya Thomas, LCSW
Licensed Clinical Social Worker
615.330.4405

MEDICAL PROFILE

NAME: _____ AGE: _____ SEX: _____ DATE: _____

Check if you have a history of:

- | | |
|---|--|
| <input type="checkbox"/> APPETITE DISTURBANCE | <input type="checkbox"/> MENTAL RETARDATION |
| <input type="checkbox"/> SLEEP DISTURBANCE | <input type="checkbox"/> HEAD INJURY |
| <input type="checkbox"/> PHYSICAL HANDICAP | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> VISION PROBLEMS | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> SEIZURES | <input type="checkbox"/> DIZZINESS |
| <input type="checkbox"/> HYPERACTIVITY | <input type="checkbox"/> SERIOUS ILLNESS |
| <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> RECENT WGT.LOSS/GAIN | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> DENTAL PROBLEMS | <input type="checkbox"/> NIGHTMARES |
| <input type="checkbox"/> BACKACHES | <input type="checkbox"/> HAYFEVER |
| <input type="checkbox"/> BEDWETTING | <input type="checkbox"/> STOMACH ACHES |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> BLACKOUTS |
| <input type="checkbox"/> MENSTRUAL PROBLEMS | <input type="checkbox"/> HORMONE TREATMENT |
| <input type="checkbox"/> ULCERS | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> PREGNANCY | <input type="checkbox"/> SKIN RASHES |
| <input type="checkbox"/> CIRRHOSIS OF LIVER | <input type="checkbox"/> MISCARRIAGE |
| <input type="checkbox"/> FREQUENT COLDS | <input type="checkbox"/> CHRONIC COUGHING |
| <input type="checkbox"/> ABORTION | <input type="checkbox"/> OVERWEIGHT |
| <input type="checkbox"/> EARACHES | <input type="checkbox"/> LOSS OF ENERGY |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> INSOMNIA |

ALLERGIES: _____

CURRENT STATE OF
HEALTH: _____ EXCELLENT _____ GOOD _____ FAIR _____ POOR _____

MEDICATIONS CURRENTLY TAKEN:

Name	Dosage	Prescribed By
------	--------	---------------

Name	Dosage	Prescribed By
------	--------	---------------

Name	Dosage	Prescribed By
------	--------	---------------

*please list additional medications currently taken on back.

ALCOHOL/OTHER DRUGS USED? How Much? How often?

TRANQUILIZERS/ANTIDEPRESSANTS TAKEN IN LAST SIX MONTHS:

How much per day? _____ How long taken? _____

Results? _____

HOSPITALIZATION DATES): _____

PAST PSYCHOTHERAPY/COUNSELING EXPERIENCE:

WITH WHOM?	DATES/DURATION?
------------	-----------------

*Please use back if more space is needed.

DESCRIBE PAST EXPERIENCE WITH PSYCHOTHERAPY/COUNSELING.
