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**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
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Name	Dosage	Prescribed By
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Name	Dosage	Prescribed By
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\*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?
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\*Please use back if more space is needed.

DESCRIBE PAST EXPERIENCE WITH PSYCHOTHERAPY/COUNSELING.

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