

III. Adult Medical History/Information Name: _____ Date: _____

Please complete this information as thoroughly as possible. Your therapist will review this form with you in the first consult appointment.

How do you rate your current health (*please circle*): *Very Healthy* *Average* *Unhealthy*

Please list your current medical doctor (Primary Care Physician):

Name: _____

Address: _____ Phone Number: _____

When did you last see your physician? _____ Reason: _____

Do you currently or have you experienced any of these issues (Please circle and identify year):

Convulsions/Seizures	Diabetes	Head Injuries	Prostrate Disease
Asthma	Dizziness	Heart Disease	Skin Disease
Blackouts	Eye Disease	Kidney Problems	Thyroid (overactive)
Cancer	Glaucoma	Liver Disease	Thyroid (underactive)

Do you have any other physical illness or problems now? ☐ No, ☐ Yes please list: _____

Have you ever seen a neurologist? ☐ No ☐ Yes , if yes when and why: _____

Have you ever had a CT or MRI on your brain? ☐ No ☐ Yes, if yes when and why: _____

Have you ever had an EEG test for seizures? ☐ No ☐ Yes, if yes when and why: _____

Do you have any physical challenges in performing routine activities? ☐ No ☐ Yes, if yes please identify:

☐ Walking up stairs ☐ Walking long distances ☐ Sitting ☐ Standing after sitting

☐ Standing ☐ Other: _____

If you have any Allergies, Please list: _____

Medication: Please list your CURRENT medications (taken within the past 30 days)

Medication Name	Dosage	Prescribing Physician	Reason for Medication	Please check if you have been informed of possible side effects

If more than seven current medications, please continue the list on the back of this sheet

If you **EVER** had medication prescribed for psychological problems (anger, stress, depression, anxiety...etc). Please list what you can remember(if you listed the medication above, you do not need to re-identify it) :

Medication Name	Dosage	Prescribing Physician	Reason for Medication & Did it Help?	Year

Have you ever been hospitalized overnight for a physical or psychological problem? ☐ No ☐ Yes, if yes please identify (if more than four, just list the latest four experiences)

Hospital	Reason	Year

Family Medical History: Please identify anyone in your family (extended and current family) that have/has any of the below issues

Issue	Person Affected	Comments
Cancer		
Diabetes		
Epilepsy		
Heart Disease		
High Blood Pressure		
Allergies		
Alcohol Problems		
Drug Problems		

Put a check mark in the column that tells best how often you have each of the following problems with your body:	Not at All	Sometimes	Most of the Time
Headaches			
Sick to my stomach			
Hungry after eating			
Not eating for a day or more at a time			
Vomiting after eating			
Eyes Itch			
Skin Itches			
Blood in saliva			
Dizzy			
Blood in stool			
Difficulty swallowing			
Tired easy			
Frequent coughing			

To the best of my knowledge, this information is true and accurate.

Signature: _____ Therapist Initials/Date: _____