INNOVATIVE FAMILY THERAPY

MEDICAL INFORMATION

NAME: _____ DATE: _____ DOB: _____

MEDICATIONS: List all medications you are currently taking (including aspirin, herbals and vitamins).

NAME DOSE

_____
_____
_____
_____

ALLERGIES YES NO

(If yes, please list all the medications you are allergic to.)

_____
_____
_____
_____

Family Physician: _____

Phone: _____

Pediatrician: _____

Phone: _____

Psychiatrist: _____

Phone: _____

Are you under a physician's care now?

YES NO

(if yes, explain why and who)

_____
_____
_____

How would you describe your overall health right now? Circle one.

Poor Unsatisfactory Satisfactory Good Very good

Do you have any concerns about your health? If yes, please explain. _____

_____

Are you currently receiving any medical treatment? If yes, please explain what type of treatment. _____

_____

When was your last physical? _____

Have you ever had any surgeries? If so please list all types of surgeries including dates.

_____

_____

_____

Please list any hospital admissions including dates.

_____

_____

_____

INNOVATIVE FAMILY THERAPY

MEDICAL INFORMATION (PAGE TWO)

NAME: _____ DATE: _____ DOB: _____

SYSTEMS REVIEW

Please check all that apply:

___ AIDS
___ Anemia
___ Arthritis, Rheumatism
___ Artificial Heart Valves
___ Artificial Joints
___ Asthma
___ Back Problems
___ Bleeding abnormally with extractions or surgery
___ Blood Disease
___ Cancer
___ Chemical Dependency
___ Chemotherapy
___ Chest Pains
___ Chronic Fatigue Syndrome
___Circulatory Problems
___ Cortisone Treatments
___ Cough– persistent
___ Diabetes
___ Emphysema
___ Epilepsy
___ Fainting or dizziness
___ Glaucoma
___ Gastrointestinal issues
___ Headaches
___Heart Murmur
___ Heart Problems
___ Hepatitis TYPE: _____
___ Herpes
___ High Blood Pressure
___ HIV Positive
___ Jaundice
___ Jaw Pain
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Nervous Problems
___ Neurological Problems
___ Pacemaker
___ Psychiatric Care
___ Radiation Treatment
___ Respiratory Disease
___ Rheumatic Fever
___ Scarlet Fever
___ Shortness of Breath
___ Sinus Trouble
___ Skin Rash
___ Stroke
___ Swelling of Feet/Ankles
___ Swollen Neck Glands
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Tumor or growth on head/neck
___ Ulcer
___ Venereal Disease

If you checked yes to any of these please explain below. _____

_____

_____

If there are any other medical issues that are not listed and you feel are relevant to your visit and overall health please state and explain. _____

_____

INNOVATIVE FAMILY THERAPY

MEDICAL INFORMATION (PAGE THREE)

NAME: _____ DATE: _____ DOB: _____

SOCIAL HISTORY

Please circle yes or no to the following questions.

YES NO Do you smoke? If yes how many years? _____
If you quit smoking how long ago did you quit? ____

YES NO Do you drink alcohol?
If yes how many alcoholic beverages do you drink a week? (approx.) _____

YES NO Is your employment physically hazardous? _____

YES NO Is your employment mentally stressful? _____

YES NO Do you take non-prescription drugs or other illicit drugs?
If yes, what type and how often? _____

YES NO In the past month has anyone criticized you for drinking or drug use?

YES NO In the past month have you felt that you needed to cut down on your drinking or drug use?

EMOTIONAL

YES NO Have you had any changes in eating habits? If yes, please explain: _____
_____

YES NO Have you had any changes in sleeping habits? If yes, please explain: _____
_____

YES NO Have you experienced periods of extreme sadness Or loss of interest in Activities? If yes, please explain: _____
_____

YES NO Have you ever experienced periods of hopelessness?

YES NO Do you ever think of suicide or harming yourself in any way?

YES NO Do you ever think of harming others?

YES NO Do you experience difficulties with fearfulness or worrying too much?

YES NO Do you regularly have difficulties concentrating?

YES NO Do you have difficulty controlling your temper?

INNOVATIVE FAMILY THERAPY

MEDICAL INFORMATION (PAGE FOUR)

NAME: _____ DATE: _____ DOB: _____

The following section is for FEMALES concerning pregnancy history

YES NO Have you ever been pregnant?

YES NO Are you currently pregnant?

YES NO Are you still having menstrual periods?
If no, please explain if the cause for stopping was something other than natural Menopause. _____
_____

YES NO Have you ever had problems with infertility?

If there is any other information pertaining to pregnancy that you feel needs to be explained please do so below. _____
_____