

Patient writes in this column.

Therapist writes in this column

Have you taken any medication for this problem?

Yes No

If so, please list the ones that you recall:

Did any of these medications cause especially bad side effects?

Did any of these medications help, at least somewhat?

What else have you tried to do to make this problem better?

To what extent does this problem interfere with your usual activities?

Are there other problems for which you are hoping to get help?

Have you had a similar problem in the past?

Yes No

Have you had a different sort of mental or emotional problem in the past?

Yes No

Have you ever been hospitalized for a psychiatric condition?

Yes No

Where?

When?

Related Past History

Patient writes in this column.

Therapist writes in this column

Have you ever attempted suicide?

Yes No

Have you ever had a pattern of eating much more or much less than other people do?

Yes No

Do you use caffeine (coffee, tea, cola) on a daily basis?

Yes No If yes, how much?

Do you use tobacco?

Yes No

Do you smoke marijuana?

Yes No If yes, how often?

Do you drink alcoholic beverages?

Yes No If yes, how often?

Was there ever a time when you were drinking more than was good for you?

Yes No

Have you ever been arrested for DUII or DWI?

Yes No If yes, how many times?

Has a doctor, counselor or family member ever advised you to quit drinking?

Yes No

Do you now or have you ever taken illicit drugs (street drugs)?

Yes No If yes, what kind and when?

Was there ever a time when drug use interfered with the rest of your life in any way?

Yes No If yes, when?

Who is your primary care physician (i.e. - family doctor)?

If you see an alternative medical provider regularly (homeopath, chiropractor, naturopath, herbalist, etc.), who and for how long?

Have you ever had surgery?

Yes No What kind and when?

Medical History

