Family Counseling Associates of Andover

Medication Management Program

Medical History Form

Please take the time to carefully complete this form, and bring it to your first medical appointment.

Name_____Date_____

Date of Birth _____ Primary Care_____

Therapist/Counselor_____ Therapist's Phone_____

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist:

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____
( ) _____

Medical History:

Current medical problems:

_____

_____

_____

_____

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Past medical problems, nonpsychiatric hospitalization, or surgeries:

_____

_____

_____

_____

Allergies_____

Current Weight _____ Height _____

Have you ever had an EKG? ( ) Yes ( ) No. If yes, when _____ .

Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements:

_____

_____

_____

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Personal & Family Medical History:	You	Family	Which Family Member?
Thyroid Disease ----------	( )	( )	_____
Anemia----------	( )	( )	_____
Liver Disease ----------	( )	( )	_____
Chronic Fatigue ----------	( )	( )	_____
Kidney Disease ----------	( )	( )	_____
Diabetes ----------	( )	( )	_____
Asthma/respiratory problems ----------	( )	( )	_____
Stomach or intestinal problems -------	( )	( )	_____
Cancer (type) ----------	( )	( )	_____
Fibromyalgia ----------	( )	( )	_____
Heart Disease ----------	( )	( )	_____
Epilepsy or seizures ----------	( )	( )	_____
Chronic Pain ----------	( )	( )	_____
High Cholesterol ----------	( )	( )	_____
High blood pressure----------	( )	( )	_____
Head trauma ----------	( )	( )	_____
Liver problems ----------	( )	( )	_____

Is there any additional personal or family medical history?

( ) Yes ( ) No If yes, please explain:

_____

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

_____

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No

If yes, Please describe when, by whom, and nature of treatment. Reason Dates Treated By Whom

_____

_____

_____

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Psychiatric Hospitalization ( ) Yes ( ) No
If yes, describe for what reason, when, and where.

_____
_____
_____
_____

Past Psychiatric Medications:

Antidepressants

- Prozac (fluoxetine) ( )
- Zoloft (sertraline) ( )
- Luvox (fluvoxamine) ( )
- Paxil (paroxetine) ( )
- Celexa (citalopram) ( )
- Lexapro (escitalopram) ( )
- Effexor (venlafaxine) ( )
- Cymbalta (duloxetine) ( )
- Wellbutrin (bupropion) ( )
- Remeron (mirtazapine) ( )
- Serzone (nefazodone) ( )
- Anafranil (clomipramine) ( )
- Pamelor (nortrptyline) ( )
- Tofranil (imipramine) ( )
- Elavil (amitriptyline) ( )
- Other_____ ( )

Anti-anxiety medications

- Xanax (alprazolam) ( )
- Ativan (lorazepam) ( )
- Klonopin (clonazepam) ( )
- Valium (diazepam) ( )
- Tranxene (clorazepate) ( )
- Buspar (buspirone) ( )
- Other _____ ( )

ADHD medications

- Adderall (amphetamine) ( )
- Concerta (methylphenidate) ( )
- Ritalin (methylphenidate) ( )
- Strattera (atomoxetine) ( )
- Other _____ ( )

Antipsychotic / Mood Stabilizers

- Seroquel (quetiapine) ( )
- Zyprexa (olanzepine) ( )
- Geodon (ziprasidone) ( )
- Abilify (aripiprazole) ( )
- Clozaril (clozapine) ( )
- Haldol (haloperidol) ( )
- Prolixin (fluphenazine) ( )
- Risperdal (risperidone) ( )
- Other _____ ( )

Sedative/Hypnotics

- Ambien (zolpidem) ( )
- Sonata (zaleplon) ( )
- Rozerem (ramelteon) ( )
- Restoril (temazepam) ( )
- Desyrel (trazodone) ( )
- Other _____ ( )

Mood Stabilizers

- Tegretol (carbamazepine) ( )
- Lithium ( )
- Depakote (valproate) ( )
- Lamictal (lamotrigine) ( )
- Tegretol (carbamazepine) ( )
- Topamax (topiramate) ( )
- Other _____ ( )

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Family Psychiatric History:

Has anyone in your family been diagnosed with, or treated for:

Bipolar disorder ( ) Yes ( ) No

Schizophrenia ( ) Yes ( ) No

Depression ( ) Yes ( )

No Post-traumatic stress ( ) Yes ( ) No

Alcohol abuse ( ) Yes ( ) No

Other substance abuse ( ) Yes ( )

Violence ( ) Yes ( ) No

If yes, who had each problem? _____

_____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse?

( ) Yes ( ) No

If yes, for which substances?

_____

_____

_____

If yes, where were you treated and when?

_____

_____

_____

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past two years? ( ) Yes ( ) No

If yes, which ones?

_____

_____

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long?

_____

_____

_____

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

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I attest that all of the information on this form is accurate to the best of my knowledge.

_____

Client Name

_____

Signature of Client, Parent or Guardian