

Family Counseling Associates, LLC

12 Essex Street | Andover, MA 01810
360 Route 101, Suite 12B | Bedford, NH 03110
152 Sylvan Street, Suite 12A | Danvers, MA 01923

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:

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

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 (nortriptyline) ()
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

Alcohol abuse () Yes () No

Schizophrenia () Yes () No

Other substance abuse () Yes ()

Depression () Yes ()

Violence () Yes () No

No Post-traumatic stress () 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