Samaritan Counseling Services

ID #: Name: **Medical Information Form**

Today's Date: ______/______/______
Name: ___________________________________ ( ) Male ( ) Female
Birth Date: ______/______/______ Race: _____________

DIRECTIONS:

Please fill out this form as completely as you can. Medical factors can play an important role in causing psychological problems, and this form is designed to ask about such problems. Some of the questions may seem overly personal, but your frank answers will let us help you in the best way we can. You may wish to consult your physician to help you answer the questions fully.

A. OVERALL HEALTH:

1. How would you rate you physical health? ___ Excellent ___ Good ____ Fair ___ Poor ___ Very Poor
   If not good, please explain why.

____

2. Do you currently experience trouble:
   ___Sleep disturbances: ___Trouble falling asleep ___Early morning waking ___Other
   ___Eating disturbances: ___Losing weight ___Gaining weight ___Other
   ___Lack of concentration: ___Marked anxiety or panic ___Fears of being alone ___Other fears
   ___Suicidal thoughts: ___Suicidal attempts ___Self harm ideas ___Self harm actions
   ___Sexual concerns: ___Loss of interest in sex ___Impotency ___Other
   ___Unexplained physical problems: ___Headaches ___Other

3. What is your current weight? __________ lbs.; What is your current height? ______ft.______in.

4. When was your last complete medical examination?
   Date: _____________________________
   Name of Physician: _________________
   City and State: ______________________
   Findings (e.g., test results) ____________
   ____

   Last gynecologic exam? (For women)
   Date: ________________________________
   Name of Physician: _____________________
   City and State: _________________________
   Findings (e.g., test results) _______________
   ____

5. Do you have any allergies?

   ______ No: Skip to next question
   ______ Yes: Please specify:

Food/medication/other	Reaction

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B. SUBSTANCE USE HISTORY:

1. Do you currently smoke cigarettes?

______ No: Skip to next question
______ Yes: How many do you smoke per day on average? ______________

2. Do you currently drink caffeinated beverages?

______ No: Skip to next question
______ Yes: How much per day on average?

Coffee ______ cups
Tea ______ cups
Soft Drinks ______ cans/bottles

3.If you drink alcoholic beverages currently, or have in the past, please describe use:

CURRENT	PAST
Beer & Wine	Beer & Wine
Liquor	Liquor
*Street/Prescription Drugs	Street/Prescription Drugs

*Include: Cocaine, crack, marijuana, LSD, codeine, Dexedrine, mescaline, valium, Quaaludes, etc.

CURRENT	PAST
*Habitual Behaviors	Habitual Behaviors

*Include: Gambling, internet, binging, purging, etc.

C. CURRENT PHYSICAL ISSUES:

1. Do you have any ***current*** physical conditions for which you receive medical care? (Include allergies)

_____ No: Skip to next question
____ Yes: Please specify below

Condition/Problem	Duration	Treatment/Medication	Results	Treating Physician

2. Do you have or suspect any ***current*** physical conditions for which you have **not** received medical care?
    _______ No: Skip to next question
    _______ Yes: Please specify below

3. Do you take any drugs or non-prescription medication, not previously mentioned (including supplements, herbal remedies, etc.)?
    _______ No: Skip to next question
    _______ Yes: Please specify below

Condition	Name of Product	How Often/How Much	Method of Use

D. PAST PHYSICAL ISSUES OR MEDICAL HISTORY

1. Do you have any *past* physical conditions for which you have received medical care?
    _______ No: Skip to next question
    _______ Yes: Please specify below

Condition/Problem	Duration	Treatment/Medication	Results	Treating Physician

2. Do you have any *past* conditions for which you have not received medical care?
    _______ No: Skip to next question
    _______ Yes: Please specify below

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3. Have you ever been turned down for life insurance, military service, or employment because of health conditions, alcohol or drug use?
   ______ No: Skip to next questions
   ______Yes: When and for what reasons?

4. Men:
   At what age did puberty begin? ______

5. Women:
   a. At what age did menstruation begin? _______
   b. Have you ever been pregnant?
   ______ No: Skip to next question
   ______ Yes: Please specify below
   ______ Number of pregnancies ______ Number of stillbirths
   ______ Number of miscarriage ______ Number of premature births
   ______ Number of abortions ______ Number of children

6. Have you ever been hospitalized for an illness or operation?
   ______ No: Skip to next question
   ______ Yes: Please specify below

Year	Illness/Operation	Hospital	City/State

7. Have you ever had a serious past medical problem which did not require Hospitalization? (e.g., mononucleosis)
   ______ No
   ______ Yes: When and under what circumstances:
   ____
   ____

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E. FAMILY HEALTH HISTORY

Please indicate with a check mark if ***you or your immediate family*** (parents, siblings, children) have a history of the following. If you check "yes" under family please indicate which family member.
(If adopted, please complete for adoptive family and check here ______).

	SELF HISTORY		FAMILY HISTORY		
	YES	NO	YES(who?)	NO	DON'T KNOW
sexually transmitted disease	___________	_____	___________	_____	_____
epilepsy	___________	_____	___________	_____	_____
head injury	___________	_____	___________	_____	_____
thyroid problem	___________	_____	___________	_____	_____
other hormone problems	___________	_____	___________	_____	_____
diabetes	___________	_____	___________	_____	_____
hypoglycemia	___________	_____	___________	_____	_____
meningitis/encephalitis	___________	_____	___________	_____	_____
alcohol abuse	___________	_____	___________	_____	_____
substance abuse	___________	_____	___________	_____	_____
schizophrenia	___________	_____	___________	_____	_____
manic-depressive disease	___________	_____	___________	_____	_____
depression	___________	_____	___________	_____	_____
panic/anxiety	___________	_____	___________	_____	_____
post-traumatic stress	___________	_____	___________	_____	_____
psychotic episode	___________	_____	___________	_____	_____
attention deficit disorder	___________	_____	___________	_____	_____
physical abuse	___________	_____	___________	_____	_____
sexual abuse	___________	_____	___________	_____	_____
emotional abuse	___________	_____	___________	_____	_____
phobias	___________	_____	___________	_____	_____
anorexia	___________	_____	___________	_____	_____
bulimia	___________	_____	___________	_____	_____
suicide attempt	___________	_____	___________	_____	_____
completed suicide	___________	_____	___________	_____	_____
excessive flow	___________	_____	___________	_____	_____
irregular periods	___________	_____	___________	_____	_____
cramps	___________	_____	___________	_____	_____
sleeping difficulties	___________	_____	___________	_____	_____
weight loss/gain	___________	_____	___________	_____	_____

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F. PREVIOUS THERAPY, COUNSELING, OR PSYCHIATRIC HOSPITALIZATIONS

______ No: You need not answer the following.
______ Yes: Please fill in the following with the most recent therapy, counseling, psychiatric hospitalizations first.

a. Dates _________________ through ___________________
Previous Therapist's Degree: ______ Trainee ______ Ph.D. ______ MSW ______M.D.
Name/Agency ________________________________ Telephone (____)______________________________
Therapist ____
Address ____
What kind of treatment? ____________________________ Frequency? ______________________________
Outcome? ____

b. Dates _________________ through ___________________
Previous Therapist's Degree: ______ Trainee ______ Ph.D. ______ MSW ______M.D.
Name/Agency ________________________________ Telephone (____)______________________________
Therapist ____
Address ____
What kind of treatment? ____________________________ Frequency? ______________________________
Outcome? ____

c. Dates _________________ through ___________________
Previous Therapist's Degree: ______ Trainee ______ Ph.D. ______ MSW ______M.D.
Name/Agency ________________________________ Telephone (____)______________________________
Therapist ____
Address ____
What kind of treatment? ____________________________ Frequency? ______________________________
Outcome? ____

I have read the Treatment and Policy Information Sheet and have filled out this form completely and accurately. I understand that the information I have given on this form will be part of my permanent record and will be treated confidentially, as is covered in the Treatment and Policy Information Sheet under "Confidentiality."

Patient's Signature: ____ Date ____________

For official use only:____

Psychiatrist:____ Date:______________

Medical Referral: ____Yes ____No Comments: ____

C: Data/SCS/Program/Forms/Clin Chart/Medical Info. Form Mar-00