MEDICAL /PSYCHIATRIC/PSYCHOTHERAPY HISTORY

COUNSELING/PSYCHOTHERAPY HISTORY

Presently in group/family/couples' counseling? ____ *yes _____no

*Reason: ______________________________ Date Started: ____________

Therapist Name: ______________________________ Phone #: ____________________

Address: ____

Past individual/group/family/couples' counseling? ____*yes _____no

*Reason: ______________________________ Dates/Duration: ____________________

Therapist/Counseling Center Name: ______________________________ Phone: ______________

Address: ____

Outcome: ____

PLEASE INDICATE BELOW ANYTHING ELSE IN YOUR HISTORY YOU FEEL IS IMPORTANT TO NOTE:

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MARGARET A. BRNICH-RYAN, MA, NCC, LPC

COMPASSIONATE GUIDANCE

MEDICAL /PSYCHIATRIC/PSYCHOTHERAPY HISTORY

NAME: ______________________________ DATE OF BIRTH: ________________

PERSONAL MEDICAL HISTORY

Physician's Name: ______________________ Telephone #: ________________________

Address: ___________________________ City: ____________ST: _____ ZIP: __________

Date of Last Physical Exam: ____________ Currently under medical care? _____ *Yes _____No

*Please describe current condition or illness for which you are being treated: ___________________

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EMERGENCY CONTACT* AND PHONE NUMBER: ___________________________________

*Their relation to you (eg, friend, sister, brother, parent, etc.)?______________________

Medications:

____________________ _______mg ______times per day Compliant? ___Yes ___No

____________________ _______mg ______times per day Compliant? ___Yes ___No

____________________ _______mg ______times per day Compliant? ___Yes ___No

____________________ _______mg ______times per day Compliant? ___Yes ___No

____________________ _______mg ______times per day Compliant? ___Yes ___No

Allergies: ____

Hospitalizations and/or Partial Hospitalizations: Please indicate year and reason for hospitalization

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FAMILY HISTORY

Please describe any serious illnesses experienced by family members including psychiatric and alcohol or other drug conditions (past and/or present):

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