Shrink inc.

Susan Thompson, LSCSW

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Health History

Name: _____

Known Allergies: _____

Psychiatrist or treating Doctor: _____

Current Medications:

Medicine	Dose (mg)	Times/day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: Please include any other medications on the back of this sheet:

Do you currently use any of the following?

Caffeine***:***
Coffee: amount/day:_____ Tea: amount/day:_____ Soft drinks: amount/day_____

Alcohol:
Beer: amount_____ per (circle one) day, week, month
Mixed drinks/neat (amount in ounces of alcohol) _____ per day, week, month

Drugs:
Marijuana amount _____ per (circle one) day, week, month

Stimulants:
Cocaine, Methamphetamine, etc. amount_____ per day, week, month

Other drugs: List type, frequency, and amount _____

_____

_____

Have you ever received treatment for addictions? When/Where_____

Cigarettes, cigars, chew tobacco, snuff amount _____ per day, week, month

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Head injuries:

Falls, accidents where you hit your head: explain _____

Concussions, closed head injuries, head injuries_____

Did you ever play football or other contact sports? _____

Have you ever lost consciousness? Explain_____

Used any inhalants, exposed to toxic materials_____

Hospitalizations/surgeries:

Age: _____ Reason _____
Age_____ Reason_____

Check any of the symptoms below…

_____ Headaches, neck pain
_____ Shortness of breath/pressure in chest
_____ Recent gain/loss of weight
_____ Epilepsy/seizures
_____ Memory loss/ increased forgetfulness
_____ Anxiety attacks/nervousness
_____ Skin problems
_____ Worrying/obsessing
_____ Anger/rages
_____ Back pain
_____ Pounding heart/fluttering
_____ Indigestion/bowel problems
_____ Vision problems
_____ Eating problems (restricting, overeating)
_____ Fatigue/more tired
_____ OB/GYN problems
_____ Phobias, fears

Sleep problems, describe:_____

Other physical problems that you are concerned about: _____

Trauma: Have you experienced any of the following?

Sexual abuse, assault (ages) _____

Physical abuse, domestic violence, assault (ages) _____

Accidents, incidents that were traumatic _____

Have you ever witnessed a traumatic event? _____

Do you have any of the following? Please check.

____ Diabetes
____ Asthma
____ Depression
____ Bipolar
____ Heart problems: _____
____ Thyroid:_____
____ Addictions: _____
____ Learning disabilities: _____