PATIENT TREATMENT AND MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

Date of last medical exam:

Current medical problems:

Current prescription medications (please provide dosages, frequency and purpose):

Name and address of physician prescribing the medications:

Allergies or adverse reactions to medication:

Previous mental health or substance abuse treatment (please provide dates, names of treatment doctors or facilities and reason for treatment):

Have any close relatives experienced emotional or psychiatric problems (please give details):

Describe your current use of alcohol and/or drugs including caffeine and nicotine (include amount and frequency of use):

What community resources are you currently utilizing?

What are the cultural or religious considerations that are important to the success of your treatment?

Are there any relevant legal issues for you or your family?

What problems do you want to work on and what are your goals for treatment: