# Medical History Form

This information is confidential

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|---|---|
| **Name:** | **Phone:** |
| **Address:** | |
| **Email:** | **Date of birth:** |
| **Relationship status:** | **Occupation:** |
| **Emergency contact person:**<br><br>**Contact's phone number:** | |
| **Physician's name:** | **Physician's Tel/city:** |
| **Current Health History -** Please list any diagnosed medical conditions you currently have (diabetes, heart disease, high blood pressure, contagious ailments (HIV, Hep C, etc.), multiple sclerosis, arthritis, fibromyalgia, chronic fatigue, etc): | |
| **Past Health History -** Please list any medical health conditions you don't currently have but have had in the past (ulcers, fractures, surgeries, hepatitis, traumatic brain injury (TBI), etc.) | |

**Current and Past Psychological Health History -** Please list any (current or past) psychological problems (depression, anxiety, OCD, bipolar, schizophrenia, borderline, sexual abuse survivor, victim of domestic violence, ritual abuse survivor etc):

**Medications & Supplements -** Please list all prescription medications, over the counter medications and supplements you are taking (include those you take every day as well as those you take occasionally like any type of sleeping pills):

**Suicidality:**
In the last 5 years, have you felt suicidal, if yes, please explain?

At any time in your life, did you attempt to commit suicide?

**Mood Altering Substance Use** – Please list any mood-altering substances you use (regularly or occasionally) such as: alcohol, nicotine, opioids, benzodiazepine, nonbenzodiazepine (Z-drugs), recreational drugs, inhalants, etc.

**Other Relevant Information** – Is there and other information you think we should know or events in your life you consider relevant to treatment:

Signature: _____ Date:_____