COMPREHENSIVE OUTPATIENT SERVICES INC. CFD ______ CRCC _____ RCC _____ SBCC _____

Please take a moment to fill out the following medical and social history for yourself. It is our policy to ask of every patient to have a physical exam as part of treatment. If you have not had a general check up in the past 12 months, you are encouraged and may be expected to get one. You will also be asked to sign an information consent form so that we may send for a copy of your medical records.

NAME: ____ DATE OF BIRTH: ____________

AGE: _______ HEIGHT: ____________ WEIGHT: __________ SEX: ________

EMERGENCY CONTACT: NAME, PHONE NUMBER ____

CURRENT PHYSICIAN OR PEDIATRICIAN: ____

ADDRESS: ____

____TELEPHONE #:____________________

LAST MEDICAL EXAM: ____

(PLEASE **DO NOT LEAVE THIS SPACE BLANK** – INCLUDE YEAR AND PLACE OF EXAM)

HOSPITALIZATIONS:

DATE	HOSPITAL	DESCRIPTION (REASON FOR ADMISSION):

Medical Problems (past and present): ____

____

____

CURRENT PSYCHIATRIC MEDICATIONS:	PRESCRIBED BY:

PAST PSYCHIATRIC MEDICATIONS:	PRESCRIBED BY:

History of reaction to psychiatric medications: (DRUG ALLERGIES): ____

____

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OTHER MEDICATIONS, INCLUDING OVER THE COUNTER MEDICATIONS:	PRESCRIBED BY:

History of reactions to non-psychiatric medication (drug allergies): ____

____

____

CURRENT SYMPTOMS: answer Yes of No unless otherwise specified.

1. Recent weight gain ______ How much ______ over ______ weeks, months, years.
Weight loss ______ How much ______ over ______ weeks, months, years.

2. General weakness: ______

3. Pain: where? ________________ Severity (scale 1-10 with 1 being minimal and 10 being most severe) _____
Frequency _______________

4. Anemia ___________

5. Diabetes _______ Type ________

6. Nutritional problem ____________________________________

7. Neurological problem _______ Describe ____
History of stroke _________

8. Thyroid problem _______________________

9. Hepatitis ______ Type _________________________

10. Chronic viral illness ________ Type ______________________________

11. Headaches ______ if yes, how often ________, description ____

12. Any dizziness ______ fainting ________seizures ________

13. Any visual problems ______ glasses used ______

14. Any hearing problems ______ hearing aids used ______

15. Any skin problems ______

16. Any chest pain ________ Do you have high blood pressure __________

COMPREHENSIVE OUTPATIENT SERVICES INC. CFD ______ CRCC _____ RCC _____ SBCC _____

CURRENT SYMPTOMS (continued): answer Yes of No unless otherwise specified.

17. Any breathing problems ______asthma ______tobacco ______

18. Allergies: to what? ____

19: Any stomach or bowel problems ________ constipation ________ diarrhea ______

20. Any problems with urination ________
If female: L.M.P. ______regular ______painful menstruation ______PMS________
# of pregnancies ______abortions ______live births________
birth control method____

21: If female: inability to have orgasms ______________
If male: impotence. ____________________

SOCIAL HISTORY

If married, date of present marriage: _________ Name of spouse: ____________________ Is this your first marriage?: YES ___ NO ___

If married before, date of marriage: ____________________ Name of spouse: ____

Were you Separated? __________ Widowed? ___________ Divorced? ____________ Dates: _______________________________

If married more than once before, please give similar information for previous marriages: ____

____

Do you have children? YES __________ NO __________ Do they live with you? YES _________ NO ____________

NAMES	AGES	DATE OF BIRTH	DO THEY LIVE WITH YOU?

Education completed: Which grade? __________ When? __________
If beyond high school, describe degrees and field of interest: ____

____

Job or occupation: ____ Brief description of duties: ______________________________________

____

Legal Issues (please provide current or past arrest, probation, or incarceration
information)____

____

Spiritual/Religious affiliation ____

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YOUR FAMILY:

	OCCUPATION	AGE	CITY OF RESIDENCE	MAJOR ILLNESSES	DATE OF DEATH AND CAUSES
MOTHER					
FATHER					
BROTHER(s)					
SISTER(s)					
STEP OR FOSTER SIBLINGS					

Reasons for coming (in your own words): ____

____

What are you looking to get out of treatment? ____

____

Have you ever seen a psychotherapist? YES __________ NO ___________

WHO	WHERE	DATES

Are you interested in having more information about support groups? YES ____ NO ____If "yes," please talk with your therapist for more information.

Have you attended any self help groups (e.g., AA, NA, or MEDA)? YES _____ NO _____ If yes, please name which ones. __________________