MEDICAL/PERSONAL HISTORY

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This form helps your therapist quickly review your current medical status and personal history so we can move on to issues that brought you to see us. Please complete the following. If you are concerned about any of these questions, please talk to Dr. Craft.

Patient's Name: _____**Age**:_____
Email: _____**Phone**: _____
Sex: (optional) M/F/LGBTQ **Marital Status:** Married Single Divorced

Who is your personal physician? _____
Name of Physician's practice: _____
Previous Psychotherapy: #years:_____ Therapist Name:_____

Please check off any of these items that apply to you and specify what they are.

_____ Have a chronic medical condition. _____
_____ Take prescription medicine on a regular basis. _____
_____ Take over the counter medication on a regular basis. _____
_____ Have allergies (to medicine, foods, pollen, etc.). _____
_____ Have been hospitalized. When? _____
For what? _____
_____ Smoke cigarettes. How many per day? _____ How long? _____
_____ Drink alcoholic beverages. How many per day? _____
_____ Drink caffeinated beverages. YES NO How many per week? _____
_____ Have recently lost weight. How much in what time? _____
_____ Have recently gained weight. How much in what time period? _____
_____ Have trouble going to sleep. _____
_____ Have trouble staying asleep. _____
_____ Sleep too much. How many hours per 24 hour period? _____
_____ Wake up early in the morning and can't get back to sleep. What time? _____
_____ Appetite has changed recently. How? _____
_____ Loss of interest in sex. _____
_____ Feel very fatigued. _____
_____ Headaches. What kind? _____ How often? _____
_____ Muscle stiffness. _____
_____ Other problem/concern. _____

In the event of an emergency, whom shall we contact?
Name: _____ Relationship to you: _____
Address: _____
Home phone: _____ Work Phone: _____
Email:_____

Educational/Occupational History:
What is your occupation? _____
Where do you work? _____
How far did you go in school? _____
How did you do in school? _____
Were you ever told you had a learning problem, dyslexia, an attention deficit, or hyperactivity? YES NO If yes, please specify: _____

Marital History (If applicable):
Spouse's name: _____ Age: _____ Occupation: _____
Date of marriage: _____ How many children do you have? ____ Ages? _____
Have you been married previously? YES NO Date(s) of previous marriage(s): _____

Religious preference, if any: _____

Family History:
Please check if any of your close biological relatives (mother, father, brother, sister, aunt, uncle, grandparent) experienced any of the following. Please indicate who it was.

Problem:	**Who?**
_____ Depression	_____
_____ Bipolar disorder ("manic depression")	_____
_____ Alcoholism/chemical abuse	_____
_____ Attention Deficit/Hyperactivity Disorder	_____
_____ Serious learning problems	_____
_____ Schizophrenia	_____
_____ Severe obesity/anorexia/bulimia/eating disorder	_____
_____ Attempted suicide (tried but lived)	_____
_____ Completed suicide (died as a result)	_____
_____ Anxiety or Panic Disorder	_____
_____ Obsessive Compulsive Disorder	_____
_____ Other psychiatric disorder	_____

Were you raised by your biological parents? YES NO If no, by whom? _____

How many siblings did you have? _____ Older sisters _____ Older brothers _____
Younger sisters _____ Younger brothers _____

Were your parents divorced? YES NO How old were you? _____

Did one of your parents or siblings die during your childhood? YES NO How old were you when this happened? _____