Personal / Medical Information

Name____Date_________________________

Current health concerns:	How long?	Previous or Current Treatment

Healthcare providers currently working with you (MDs, Psychotherapists, Naturopathic Doctors, Chiropractors, etc.):	For what issues?

Current medications, herbs, supplements	For what condition?	Prescribed by whom?

Past surgeries, major illnesses, emergency care, significant medical history	When/ How long?	Kind of treatment received?	Any remaining concerns?

Previous psychological/psychiatric/ substance abuse services?	When/ How long?	Kind of service received?	Any remaining concerns?

Substances	Frequency/pattern of use, and/or when last used? (Leave blank if none)
Alcohol	
Tobacco	
Marijuana/Hashish	
Cocaine/Crack	
Amphetamine/Crank	
LSD/Other psychedelics	
Heroin/Other opiates	
Other________________	