Desert Sage Counseling
Medical and Psychological History Form

Client's Name: ______________________________________ Date: _______________

Section 1 – *Your Personal History:*

If you are experiencing any of the following symptoms now, please place a check next to the "yes" line. If you have experienced any of these in the past, but are not experiencing the symptom currently, please put a "P" on the "yes" box.

YES	NO		YES	NO	
___	___	Depressed Mood	___	___	Restlessness
___	___	Less interest in things	___	___	Shortness of breath
___	___	Less pleasure in things	___	___	Rapid heart rate
___	___	Loss of weight	___	___	Dizzy or light headed
___	___	Weight gain	___	___	Nausea or abdominal distress
___	___	Insomnia	___	___	Inability to control thought/action
___	___	Early morning awakening	___	___	Being keyed up or on edge
___	___	Agitation	___	___	Trouble with concentration
___	___	Loss of energy, tiredness	___	___	Irritability
___	___	Feeling of low self esteem	___	___	Starving yourself
___	___	Feelings of guilt	___	___	Food binges/compulsive eating
___	___	Forgetfulness	___	___	Purging (Voluntary vomiting)
___	___	Suicidal thoughts	___	___	Sexual problems
___	___	Racing thoughts	___	___	Multiple body pains
___	___	Seeing visions	___	___	Problems with alcohol
___	___	Hearing voices	___	___	Problems with prescription drugs
___	___	People plotting against you	___	___	Problems with street drugs
___	___	Obsessive thoughts	___	___	Hospitalized: drugs or psychiatric
___	___	Feelings of being controlled	___	___	Previous counseling
___	___	Flashbacks/nightmares	___	___	Current couple problems
___	___	Mood Swings	___	___	Physical, sexual, emotional abuse
___	___	Fears	___	___	Uncontrollable anger
___	___	Panic attacks	___	___	Uncontrollable crying
___	___	Feelings of anxiety or nervousness	___	___	Other ________________________
___	___	Recent loss of loved one			

Section 2 - *Brief Drug History:* Please record your drug history by checking any that apply to you.

Past	Present		Past	Present	
___	___	Alcohol	___	___	Cocaine
___	___	Marijuana	___	___	Opiates
___	___	LSD	___	___	Inhalants
___	___	Methamphetamines	___	___	Other ________________

Section 3 - *Family History:* Please indicate which family member has or has had a problem.

YES	NO		Family Member	YES	NO		Family Member
___	___	Heart trouble	_______________	___	___	Diabetes	_________________
___	___	Nervous conditions	_______________	___	___	Cancer	_________________
___	___	Sexual Abuse	_______________	___	___	Depression	_________________
___	___	High blood pressure	_______________	___	___	Physical/Emotional Abuse	_________________
___	___	Suicide/Suicide Attempt	_______________	___	___	Drugs/Alcohol Problem	_________________