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LICENSED PSYCHOTHERAPIST

Brief Medical History

Client Name: _____ DOB: _____
Primary Care Physician: _____ Phone: _____
Last Medical Exam: _____
List any medical problems that you are currently experiencing:

Name of the physician monitoring the condition(s): _____
List any medications you are currently taking _____

Who prescribed the medication(s)? : _____
Have you ever seen a psychiatrist before? Yes ___ No ___
When: _____ Reason: _____
Previous hospitalization? _____

Check any of the following problems that you experience:

- | | |
|---|---|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Not Thinking Clearly/Confusion |
| <input type="checkbox"/> Excessive Drinking | <input type="checkbox"/> Appetite Disturbance (more/less) |
| <input type="checkbox"/> Anger/Frustration | <input type="checkbox"/> Delusions/Hallucinations |
| <input type="checkbox"/> Excessive Drug Use | <input type="checkbox"/> Low Self Esteem |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Relationship Problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty Concentrating |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Feelings of Unreality |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Intrusive Thoughts | <input type="checkbox"/> Bladder Control Problem |
| <input type="checkbox"/> Difficulty Relaxing | <input type="checkbox"/> Chills/ Hot Flashes |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fears/ Phobias |
| <input type="checkbox"/> Obsessive Thoughts | <input type="checkbox"/> Compulsive Behaviors |
| <input type="checkbox"/> Marital/ Family Problems | <input type="checkbox"/> Poor Impulse Control |
| <input type="checkbox"/> Difficulty Trusting | <input type="checkbox"/> Physical Pain |
| <input type="checkbox"/> Low Energy | <input type="checkbox"/> Sleep Disturbance (more/less) |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Worthlessness |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Sadness/ Loss |
| <input type="checkbox"/> Thoughts of Hurting Someone | <input type="checkbox"/> Isolation/ Social Withdrawal |
| <input type="checkbox"/> Thoughts of Hurting Yourself | <input type="checkbox"/> Trembling/shaking |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Tingling/ Numbness |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Lose Track of Time | <input type="checkbox"/> Physical Abuse Issues |
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Sexual Abuse Issues |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Spousal Abuse Issues |