Stopping the Chase Counseling

MEDICAL INFORMATION

1. **Patient Name _____**

Have you ever been treated for emotional difficulties before (When and Where?)

Physician: Name/Practice _____ Address_____ Phone

Date of last physical exam _____ Height _____ Weight

How is your general health now? _____

Any medical conditions that affect your quality of life?_____

Medications?

Are you presently being treated by a physician for any physical condition?

Have you had any serious illness? (List)

Have you ever had any surgery? (List)

PLEASE MARK ALL THAT APPLY: (If more than one patient, please separately initial)

___Anger	___Grief	___Paranoia
___Anxiety	___Guilt	___Physical Aggression
___Behavior Problems	___Hallucinations	___School/Work Problems
___Changes in Appetite/Eating Habits	___Hopelessness	___Self Abusive Behavior
___Criminal Activity	___Hyperactivity	___Sleep Disturbance
___Decreased Energy	___Impulsiveness	___Somatic Complaints
___Delusions	___Interpersonal Conflicts	___Suicidal Thoughts/Attempt
___Depressed Mood	___Irritability	___Weight Gain
___Disruption of Thought Process/Content	___Manic	___Weight Loss
___Emotional/Physical/Sexual Trauma	___Mood Swings	___Worthlessness
___Excessive Crying	___Oppositional	___Other (Specify)
___Family Conflicts	___Panic Attacks	

How could your life be better?

You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained and licensed/certified