

## Confidential Medical Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you had a physical examination in the last six months?      \_\_\_\_\_ yes      \_\_\_\_\_ no

Do you have any concerns about your physical health?      \_\_\_\_\_ yes      \_\_\_\_\_ no

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Are you currently under a doctor's care?      \_\_\_\_\_ yes      \_\_\_\_\_ no

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Are you currently taking any prescription medication?      \_\_\_\_\_ yes      \_\_\_\_\_ no

If yes, please list here: \_\_\_\_\_

\_\_\_\_\_

Are you currently taking any over-the-counter medications?      \_\_\_\_\_ yes      \_\_\_\_\_ no

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you ever had a head injury or lost consciousness?      \_\_\_\_\_ yes      \_\_\_\_\_ no

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized?      \_\_\_\_\_ yes      \_\_\_\_\_ no

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you had previous therapy?      \_\_\_\_\_ yes      \_\_\_\_\_ no

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Please check the frequency of the following:

	Frequently	Occasionally	Seldom	Never
Coffee				
Alcohol				
Cigarettes				
Aspirin				
Painkillers				
Tranquilizers				
Stimulants				
Marijuana				
Cocaine				
Hallucinogens				
Diarrhea				
Constipation				
Stomach trouble				
Nausea				
Vomiting				
Insomnia				
Hypersomnia				
Early awakening				
Fitful sleep				
Fatigue				
Hypertension				
Palpitations				

	Frequently	Occasionally	Seldom	Never
Dizziness				
Chest pain				
Allergies				
Asthma				
Muscle spasms				
Tingling				
Numbness				
Tics				
Twitches				
Tremors				
Fainting spells				
Blackouts				
Visual problems				
Hearing problem				
Convulsions				
Hear things				
See things				
Headaches				
Migraines				
Back pain				
Tension				
Trouble relaxing				
Ulcers				

	Frequently	Occasionally	Seldom	Never
TMJ (jaw clenching)				
Panic attacks				
Sexual problems				
Poor appetite				
Overeating				