Mass Bay Counseling

Medical History Form

Directions: Please complete this form to best of your knowledge. If patient is a child, fill out for the child. **Please complete both pages of this form.** Your records are confidential & cannot be released without your written consent

Patient Information:				
Last name:	First name:	Mid. In.	Date of birth:	*Social Security No.:*
Street Address:	City:	State & Zip code		*Okay to send letter?* ☐ *Yes* ☐ *N*
Home phone number: Ok to leave message? ☐ Yes ☐ No	Cell phone number: Ok to call? ☐ Yes ☐ No	Work phone number: Ok to call? ☐ Yes ☐ No		*Which is the best way to reach you?*
Name of insurance company:	Policy number:	*Subscriber (person) and his/ her Social Security Number & DOB:*		
Name of secondary insurance co.: **We may not be able to bill a 2nd insurance**	Policy number:	*Subscriber (person) and his/her SSN & DOB:*		
Emergency contact name & number (parent or guardian for child):	Marital status: ☐ single without partner ☐ single with partner ☐ married ☐ separated ☐ divorced ☐ widowed How long? How many children? How people in your house?			

Physician(s):		
Name:	Name:	Name:
Address:	Address:	Address:
Phone:	Phone:	Phone:
PCP or Specialty:	Specialty:	Specialty:

Current Medications:					
Current medication:	For what condition?	Dosage:	Frequency:	Date started:	Comments:

Do you have allergies to any medications? ☐ Y ☐ N **If so, which medications?**

Current or Previous Mental Health Treatment: (includes counseling, behavioral or addictions treatment)				
Name of provider (individual or agency)	For what condition?	Dates:		Comments:

Past psychiatric medications:					
Medication:	For what condition?	Dosage:	Frequency:	Dates:	Why stopped:

For all clients check all that apply: (parents, please answer for your child)

Are you now or have you ever been treated for (Check all that apply)

High blood pressure ☐ I have ☐ a family member has/had	**Seizures** ☐ I have ☐ a family member has/had	**Neurological disorders** (stroke, MS, ALS, etc.) ☐ I have ☐ a family member has/had
Diabetes ☐ I have ☐ a family member has/had	**Head Injury** ☐ I had. If so, when?	**Migraines** ☐ I have ☐ a family member has/had
High cholesterol ☐ I have ☐ a family member has/had	**Sleep apnea** ☐ I have	**Heart disease** ☐ I have ☐ a family member has/had
Thyroid problems ☐ I have ☐ a family member has/had	**Chronic pain** ☐ I have	**Cancer**, if so what kind? ☐ I have ☐ a family member has/had
Hepatitis A B or C or HIV ☐ I have if so, which?	**Asthma** ☐ I have	**Other:** Use space below to explain

Have you or a family member had a psychiatric disorder (depression, anxiety bi-polar (manic-depression) disorder or schizophrenia)? ☐ Yes ☐ No
If so, who and what disorder?

Has a family member had drug or alcohol problems? ☐ Yes ☐ No If so who?

Have you ever had any surgeries? ☐ Yes ☐ No If so, what?

Have you had any accidents or injuries requiring medical treatment? ☐ Yes ☐ No If so, what?

Have you been hospitalized for any medical condition? ☐ Yes ☐ No If so, what?

Smoking History: ☐ Currently smoke. If so, how many cigarettes per day? ☐ Never smoked ☐ Quit When?

Alcohol consumption: How many drinks per week? ☐ Currently in recovery How long sober?

Drug use: Do you use drugs? ☐ Yes ☐ No If so what? _____
☐ Currently in recovery. How long sober? Have you received treatment? ☐ detox ☐ residential ☐ NA/AA ☐ other

Are you now or have you ever been in a relationship where you have felt hurt or threatened? ☐ Y ☐ N

Would you like to discuss problems related to emotional, physical, or sexual abuse or violence? ☐ Y ☐ N

For females only:

Are you pregnant now? ☐ Yes ☐ No If so, what is your due date? Are you trying to become pregnant? ☐ Yes ☐ No

If I am taking psychiatric medications, I understand that I should speak with my doctor before attempting to become pregnant. Initial:

How many pregnancies have you had? How many births?

At what age did your menses (periods begin)? Have they stopped? (are you in menopause?) ☐ Yes ☐ No If so, at what age?

For children:

Birth History: ☐ Full term If not, what was baby's gestational age? Birth complications?

Up to date on immunizations? ☐ Yes ☐ No If not why not?

Has your child had (check all that apply)

☐ Frequent ear infections	☐ Ear tubes	☐ Hearing impairment	☐ Fine motor problems
☐ Gross motor problems	☐ Special education services	☐ "CORE" evaluation	☐ Early Intervention Services
☐ Learning disabilities	☐ Severe nightmares/ terrors	☐ Bedwetting after age 4	☐ Other:

Additional information or details of above:

Signature:

To the best of my knowledge the above information is accurate.

Name of person completing form: Signature: Date:

For office use: Reviewed by: Date:

Rev. 04/2015