

MEDICAL PROFILE

NAME: _____ **AGE:** _____ **SEX:** _____ **DATE:** _____

Check if you have a history of:

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|---------------------------|----------------------------|-------------------------|
| -----APPETITE DISTURBANCE | -----MENTAL RETARDATION | -----SLEEP DISTURBANCE |
| -----HEAD INJURY | -----PHYSICAL HANDICAPS | -----VENEREAL DISEASE |
| -----HEARING PROBLEMS | -----PSYCHIATRIC TREATMENT | -----VISION PROBLEMS |
| -----HIGH BLOOD PRESSURE | -----SEIZURES | -----DIZZINESS |
| -----HYPERACTIVITY | -----SERIOUS ILLNESS | -----RINGING IN EARS |
| -----ANEMIA | -----RECENT WGT.LOSS/GAIN | -----HEADACHES |
| -----DENTAL Problems | -----NIGHTMARES | -----BACKACHES |
| -----HAYFEVER | -----BEDWETTING | -----STOMACH ACHES |
| -----ASTHMA | -----BLACKOUTS | -----MENSTRUAL PROBLEMS |
| -----ULCERS | -----HEPATITIS | -----PREGNANCY |
| -----SKIN RASHES | -----CIRRHOSIS OF LIVER | -----MISCARRIAGE |
| -----FREQUENT COLDS | -----CHRONIC COUGHING | -----ABORTION |
| -----OVERWEIGHT | -----EARACHES | -----LOSSOF ENERGY |
| -----DIABETES | -----INSOMNIA | -----FREQUENT MEDICAL |
| | | PROBLEMS |
| -----SOILING | -----HORMONE TREATMENT | |

ALLERGIES: _____

CURRENT STATE OF HEALTH: _____ **EXCELLENT** _____ **GOOD** _____ **FAIR** _____ **POOR** _____

MEDICATION CURRENTLY TAKEN:

HOW MUCH? _____ How often? _____ Prescribed by? _____ None _____

ALCOHOL/OTHER DRUGS USED?

How much? _____ How often? _____ Prescribed by? _____ None _____

TRANQUILIZERS/ANTIDEPRESSANTS TAKEN IN LAST SIX MONTHS:

Type	How much per day?	How long taken?	Results?	None
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PRIOR MENTAL HEALTH COUNSELING OR TREATMENT NONE: _____

HOSPITALIZATION (DATES): _____

MENTAL HEALTH CENTER (DATES): _____

SOCIAL AGENCY (DATES) _____

PRIVATE PRACTICE (DATES, PRACTITIONER): _____