LEAD Behavioral Health

Medical History

Name: _____ Age: _____ Date of Birth: _____

Personal Physician: _____

Last Medical Exam: _____

List all medications you are currently taking and doses, if known:

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Who prescribed the medications? _____

List any medical problems you are currently experiencing: _____

_____

Have you been seen by a physician for these problems? ☐ Yes ☐ No

If YES, by whom? _____

Please check any of the following problems which may pertain to you:

☐ Change in Appetite	☐ Sleeping Difficulty	☐ Depression
☐ Alcohol Use/Abuse	☐ Sexual Problems	☐ Panic/Anxiety
☐ Drug Use/Abuse	☐ Eating Problems	☐ Loneliness
☐ Lack of Concentration	☐ Suicide Attempts	☐ Shyness
☐ Anger Management	☐ Marital/Family Problems	☐ Lack of Energy
☐ Allergies to Medications	☐ Dysfunctional Relationship	☐ Crying Spells
☐ Internet/Gaming Problems	☐ Pornography Problems	☐ Pain

☐ History of Physical or Sexual Abuse / Assault

Have you received psychiatric help or counseling of any kind before? ☐ Yes ☐ No

If yes, when, and please explain the nature of your consultation: _____

_____

_____

Have you received treatment for alcohol or drug abuse/dependence? ☐ Yes ☐ No

If yes, when, and please explain the nature of your treatment, including current status: _____

_____

_____

Is your visit today court ordered? ☐ Yes ☐ No If yes, please provide details:

_____

_____

Is your visit today work-related? ☐ Yes ☐ No

Date Completed: _____

Revised: February 2011