

**PERSONAL AND MEDICAL DATA FORM (Adult)**

Name \_\_\_\_\_ Today's date \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Ethnicity \_\_\_\_\_

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Specific reason for today's visit \_\_\_\_\_

Do you have any of the following concerns?

- Anxiety/ panic/OCD       Sleeping problems       Alcohol / drug problems
- Depression       Dramatic mood swings       Anger problems
- Suicidal thoughts       Problems focusing       Problems functioning
- Eating concerns (i.e. anorexia/ bulimia)       Experiencing "unreal" thoughts or having hallucinations

Are you currently taking any psychiatric medication? If yes, please list each med and the dosage:  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had a bad reaction to a psychiatric medication? If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Any history of:  Psychiatric hospitalization     Suicide attempt     Alcohol/ drug rehabilitation

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**MEDICAL CONCERNS:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Indicate which of the following you have experienced or are currently experiencing:

- Heart problems       High blood pressure       Seizure       Major head injury
- Thyroid problems       Stomach problems       Diabetes       Asthma
- Menstrual problems       Currently pregnant or breast-feeding

Other Medical Concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medication? (if yes, please list) \_\_\_\_\_

Are you taking any medical medications/ herbal/ over the counter medications on a regular basis? If yes, please list each med and the dosage: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL CARE:**

Do you have a regular healthcare provider (i.e. PCP)? \_\_\_\_\_ Last visit: \_\_\_\_\_

Last time you had your blood drawn? \_\_\_\_\_ Results: \_\_\_\_\_