Pathways Counseling Center, Inc.

Medical History

(At Time of Intake)

Client Name: _____ Date: _____

Please answer the following questions to the best of your knowledge.

Describe any current physical or mental health problems:

_____
_____
_____
_____

What medications are you currently taking? *(Please fill out the following chart - attach an additional list if necessary.)*

Current Medications	For what Condition	Dosage	Frequency	Date started	Comments/Problems/Concerns

Have you ever had:	**Yes**	**No**	**If yes, please explain**
Heart Problems	___	___	_____
Liver disease	___	___	_____
Glaucoma	___	___	_____
Seizures	___	___	_____
High blood pressure	___	___	_____
Chest pain	___	___	_____
Head injury or loss of consciousness	___	___	_____
Encephalitis or brain infections	___	___	_____
Tics or unusual movement of your body	___	___	_____
Problems with your thyroid gland	___	___	_____

Have you ever had:	**Yes**	**No**	**If yes, please explain**
HIV	___	___	_____
Tuberculosis (TB)	___	___	_____
Hepatitis C	___	___	_____
Hepatitis B	___	___	_____
Other	___	___	_____

Do you have any chronic health problems (e.g. asthma, diabetes, etc.)?
How have these problems impacted your mental health?

_____
_____
_____

Do you have any allergies? Please list them, along with any related important information about your allergies.

_____
_____
_____

If you are under the care of a physician for any of the above, please write the name and number of your doctor:

Name: _____ Clinic: _____ Telephone Number: _____

I have answered these questions to the best of my knowledge:

Client Signature _____ Date: _____