AFFILIATED FAMILY COUNSELORS/

PSYCHIATRIC CONSULTANTS OF WICHITA

MEDICAL HISTORY

PATIENT'S NAME_____ DATE OF BIRTH _____

PARENT/GUARDIAN_____TODAY'S DATE_____

REASON FOR VISIT:

_____

_____

_____

PREVIOUS MENTAL HEALTH TREATMENT? ____YES ____NO

If yes, please list previous provider/agency:

_____

_____

_____

May we request medical records from this provider? ____YES ___NO

Approximate date(s) of treatment_____

Medications prescribed in the past:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PRIMARY CARE PHYSICIAN:_____

May we contact your Primary Care Physician? ____YES ____NO

OTHER MEDICAL PROVIDERS OR THERAPISTS INVOLVED IN YOUR CARE:

_____
_____
_____

MEDICAL PROBLEMS

	SELF	FAMILY
DIABETES	_____	_____
HYPERTENSION	_____	_____
CANCER	_____	_____
EPILEPSY/SEIZURE	_____	_____
ASTHMA	_____	_____
HEART DISEASE	_____	_____
STROKE	_____	_____
LUNG DISEASE	_____	_____
MIGRAINES	_____	_____
ARTHRITIS	_____	_____
DEPRESSION	_____	_____
ANXIETY	_____	_____
MENTAL ILLNESS	_____	_____

CURRENT MEDICATION
LIST:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

OVER THE COUNTER
MEDICATIONS:_____
_____
_____
_____
_____

MEDICATION
ALLERGIES:_____
_____
_____
_____

ALCOHOL USE:

FREQUENCY _____ AMOUNT _____

PLEASE LIST ANY ADDITIONAL INFORMATION THAT YOU FEEL WOULD BE HELPFUL FOR THE PROVIDER TO KNOW REGARDING TODAY'S VISIT: