Gold Circle Counseling LLC

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MEDICAL INFORMATION

NAME_____**DATE:**_____

What is the reason you are seeking help at this time:

_____

_____

_____

PLEASE CHECK THE ITEM BELOW WHICH APPLY TO YOU IN THE PAST 6 MONTHS:

- ☐ Change of Appetite
- ☐ Loss of weight
- ☐ Weight Gain
- ☐ Binge or Purge
- ☐ Worried about your weight
- ☐ Trouble Sleeping
- ☐ High energy
- ☐ Low Energy
- ☐ Restless/difficulty sitting still
- ☐ Anxious or nervous
- ☐ Loss of Interest
- ☐ Feel like mind playing tricks
- ☐ Worried about your appearance
- ☐ Forgetfulness memory or problems
- ☐ Anger
- ☐ Verbal fighting
- ☐ Physical fighting
- ☐ Sexual problems
- ☐ Difficulty concentrating
- ☐ Racing thoughts
- ☐ Sad or depressed
- ☐ Crying Spells
- ☐ Thoughts of suicide
- ☐ Self hurt/harm

Have you ever had counseling/therapy or medication for any of the above☐Yes☐No

If "Yes" where, when, and from whom?_____

_____

_____

Who is your primary care physician?_____

How do you rate your overall health?☐Excellent☐Good☐Fair☐Poor

What is your main concern about your health?_____

_____

_____

Any other medical problems? If "Yes", please describe_____

_____

_____

PLEASE COMPLETE THE FOLLOWING REGARDING YOUR CURRENT MEDICATION:

NAME OF MEDICATION	PRESCRIPTION YES/NO	WHEN PRESCRIBED	AMOUNT DAILY	REASON

Have you every been in the hospital?_____Yes_____No. For What?_____
When?_____For how long?_____
Have you every had surgery? Yes_____No_____. What was the procedure?_____
_____ When was it done?_____
Do you have any allergies? _____Yes_____No. If "Yes" please describe_____
_____
Do you currently use illicit drugs? _____Yes_____No.
Have you every abused prescription or illicit drugs?_____Yes_____No.
How many alcoholic beverages do you consume on an average day?_____
How many per week?_____
Do you use nicotine?_____Yes_____No How much?_____
Do you use caffeine?_____Yes_____No How much?_____

HAVE YOU EVER:

Thought you should cut down on your drinking or drug use? ____Yes____No
Been annoyed when others have asked you about your drinking or drug use? ____Yes____No
Felt guilty about how much you drink or use? ____Yes____No
Had a drink/used to get join or to treat a hangover ? ____Yes____No
In trouble with the law, family members, friends when you drink or use? ____Yes____No
Do you usually get into trouble when you drink/use? ____Yes____No
Do you gamble?_____Yes_____No
How many times per month?_____
What percent of your monthly income do you spend per month on gambling?_____
Have you ever felt the need to bet more & more money?_____
Have you ever had to lie to people important to you about the extent of your gambling?_____
Have you ever seen a psychiatrist or seen a counselor before _____Yes_____No
By whom & when?_____
What was helpful?_____
What wasn't helpful?_____

PLEASE CHECK THE ITEMS BELOW THAT DESCRIBE MEDICAL SYMPTOMS YOU HAVE HAD IN THE PAST 12 MONTHS.

☐ persistent cough
☐ thyroid disease
☐ abnormal heartbeat
☐ severe/persistent headaches
☐ seizures
☐ muscle weakness
☐ joint/aches/pain
☐ kidney infection/disease
☐ urinary infection
☐ stomach/abdominal/pains
☐ change in vision/trouble with eyes
☐ change in sense of smell
☐ pain in mouth or trouble swallowing
☐ speech problems

☐ shortness of breath
☐ high blood pressure
☐ balance problems/falling
☐ loss of consciousness
☐ numbness or weakness of limbs/body
☐ muscle pain
☐ bruise easily
☐ trouble urinating
☐ liver disease
☐ vomiting
☐ changing in hearing/trouble with ears
☐ feeling clumsy or dropping things
☐ sore/swollen neck/glands
☐ voice problems

Do you give us permission to contact your physician? ☐ Yes ☐ No
Do you give us permission to contact your psychiatrist? ☐ Yes ☐ No

Signature_____ Date_____
Signature of parent if completed on behalf of a minor child_____

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Therapist Signature_____Date Reviewed_____
Referred for physical exam? ☐ Yes ☐ No
To Whom?_____Client willing to accept referral ☐ Yes ☐ No
Referred for psychiatric evaluation? ☐ Yes ☐ No
To Whom?_____Client willing to accept referral ☐ Yes ☐ No