Elizabeth Nyblade, Ph.D.
Clinical and School Psychologist
1313 East Maple Street, Suite 214 • Bellingham, WA 98225-5708
Phone: 360-647-8295 • FAX: 360-647-8296 • e-mail: enyblade@mindingyourspirittogether.com

Medical History and Status
(Adult and Adolescent Men)

We appreciate your help in sharing the following confidential information.
It will assist us in providing better care and coordinating your treatment with your physician. Thank you.

Name: _____ Date: _____Date of Birth: _____ Age: _____
_____ I have no current doctor. My family physician is _____
_____ I have shared the issues that bring me here with my MD. _____ My MD is aware I have come here.
My last visit to a physician was: _____ (give month and year)
My last complete physical examination was: _____ (give month and year)

Recent Health Issues:

How would you describe your health at the present time? _____ Unsure __ Poor __ Fair __ Good __ Excellent
In the last five years, have you had a serious accident? _____No _____Yes
In the last five years, have you been disabled by any injury, temporarily or permanently? _____No _____Yes
In the last five years, have you had a serious or chronic illness? _____No _____Yes
In the last five years, have you had any operations or surgeries? _____No _____Yes
In the last five years, have you had any other hospitalizations? _____No _____Yes
Do you currently take any prescription medication daily? _____No _____Yes
Do you currently take any over-the-counter or herbal medication daily? _____No _____Yes

Allergies:

_____ I have no known allergies.
_____ I am allergic to the following foods: _____
_____ I am allergic to the following medications or drugs: _____
_____ I am allergic to the following environmental conditions (e.g., dust, pollens): _____
_____ I am allergic to the following manufactured substances (e.g., latex, x-ray dyes): _____

Preventive Practices:

Do you generally eat a well-balanced diet? ___ Never _____ Sometimes ___ Often ____Always
Do you participate in regular exercise or physical activity? ___ Never _____ Sometimes ___ Often ____Always
What is your regular physical activity? _____
Do you participate in a hobby for 3+ hours per week? ___ Never _____ Sometimes ___ Often ____Always
What are your hobbies? __ TV (___ hours daily) ___ Reading (__ hours daily) ___ I take ____vacation days/yr.
Other hobbies _____
Do you belong to any social or other groups (like church, sports team, etc.) that you meet with regularly?
_____ No_____ Yes What groups? _____

Previous Mental Health Treatment:

I have previously participated in counseling, psychotherapy or marriage counseling. _____ Yes _____ No
Please list the names of previous local counselors, the approximate dates of therapy and the circumstances:

_____
I have previously seen a psychiatrist for therapy (____ Yes ____ No) or for prescriptions (____ Yes_____ No)
I have previously taken medications for the brain, or mental health (e.g. tranquilizers) _____ Yes_____ No

Substance Use History:

For each substance **ever** used and not prescribed for your use in this way, please complete the following:

Substance	Never Used	Used at Least Once	Age at First Use	Age at Last Use	Current Amount Used: (specify day or week)	Might this be problem for you?
Caffeine						
Tobacco products (which?)						
Alcohol						
Tranquilizers						
Marijuana						
Recreational stimulants						
Narcotics pain killers						
Hallucinogens						
Steroids						
Heroin, morphine, or opium						
Designer drugs (PCP, Ecstasy)						
other: (which?)						
other: (which?)						
other: (which?)						

Has use of a substance ever affected your work performance, or resulted in legal charges? _____ Yes _____ No
I have been clean and sober (from alcohol, recreational drugs and abusive use of prescribed drugs) since _____
I have previously participated in alcohol or drug treatment. _____ Yes _____ No
List the treatment centers or counselors for substance abuse you used:

_____

I currently make use of substance abuse counseling or support groups. _____ Yes _____ No
I have made use of substance abuse counseling or support groups in the past. _____ Yes _____ No

Current Medications:

Please list any medications (prescription, over-the-counter, herbal) you are currently taking daily:

Name of Medication	Who Prescribes?	Current Dosage	For What Condition?	Approximate Date Began?

_____ I am unsure of my medication information.
_____ I want to discuss this with my therapist or evaluator.
_____ I take more than five medications daily

Medical Symptom History and Status

Do you have or have you ever had any **severe or frequent problems**,
or **problems requiring medical intervention** in any of the following areas?

Please check: N for **Never a Problem**. **H** for **History of this Problem** or **C** for **Current (in last 6 months)**

N	H	C	
			Health generally poor, usually feel poorly
			Fatigue, lack of energy
			Unexplained loss or gain in weight
			Insomnia, difficulty falling or staying asleep, restless sleep
			Nausea, vomiting, diarrhea, constipation
			Major mental illness
			Suicidal thoughts, or attempts, self harm
			Severe mood swings, periods of moodiness
			Physical or sexual abuse as a child
			Abuse by an adult partner
			Disabled from work for physical reasons
			Disabled from work for mental or mental health reasons
			On the job injury that prevented return to work
			Hearing voices that other people do not hear
			Acting as caretaker for ill or disabled family member
			Having to avoid certain things, places or activities that frighten you
			Worrying too much about things
			Nervousness, restlessness or shakiness inside
			Tears in eyes or crying easily
			Trouble getting your breath
			Frequent colds or sore throat
			Spells of terror, anxiety or panic
			Chronic Fatigue Syndrome, Fibromyalgia
			Loss of interest and pleasure in activities or people
			Migraines or chronic headaches
			Loss of sense of taste or smell
			Fainting, blackouts or loss of consciousness
			Concussion, head injury, stroke
			Problems with balance
			Concentration or memory problems
			Major blow to the head, in fight, assault, car accident etc.
			Numbness or tingling in parts of your body
			Brain fever (meningitis, encephalitis, etc.)
			Loss or change in vision or hearing
			Diabetes, high or low blood sugar, abnormal thirst
			High blood pressure
			Heart attack, congestive heart problems, coronary condition
			Anemia, blood disease, unusual bruising or bleeding
			Abdominal discomfort, colitis
			Binge eating, extreme dieting, poor appetite
			Change in bowel habits
			Indigestion, ulcer disease, blood in stool
			Liver difficulties, Hepatitis
			Unwanted thoughts, words, or ideas that won't leave your mind

Please check: N for **Never a Problem**. **H** for **History of this Problem** or **C** for **Current (in last 6 months)**

N	H	C	
			Having to repeat the same actions such as touching, counting, washing
			Having to check and double-check what you do
			Low back pain
			Other chronic pain
			Upper back or neck pain or condition
			Birth defect, developmental problems
			Thyroid problems
			Vitamin or mineral deficiency
			Hormone difficulties
			Anger or temper problems
			Legal involvements with medical care
			Legal involvements with mental health care
			Cancer or tumor
			Other issues of concern:
			Other issues of concern:

Male Health Issues:

Date of last PSA check _____ _____ I never had one _____ I don't know if I've had one.
Date of last prostate examination _____ _____I never had one ____ I don't know if I've had one.
Currently sexually active? _____ Yes _____ No
Current contraceptive in use? _____ _____ I never used one _____ I don't know about contraception.

Do you have or have you ever had any **severe** or **frequent problems** or
problems that have required medical intervention in any of the following areas?

Please check: N for **Never a Problem**. **H** for **History of this Problem** or **C** for **Current (in last 6 months)**

N	H	C	
			Genital pain
			Sexual concerns

The information I have provided about my medical condition is true and correct to the best of my knowledge.

Pt. Signature: _____Date _____Clinician Review _____Date: _____