MEDICAL HISTORY

PLEASE PRINT. (Fill out a separate medical history sheet for each person.)

Date _____

Name _____

Currently under doctor's care: Yes No

Name of doctor(s) involved in your care: ----------

Health Problems (including allergies): _____

_____

Medication currently used: None

Medication	Dosage	Doctor Prescribing	Why Prescribed
----------	_____	----------	----------
----------	_____	_____	_____
----------	----------	----------	_____
----------	_____	_____	_____

Previous Counseling or Chemical Dependency Services: None

Date(s)	Facility/Therapist	Reason(s)	Helpful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Hospitalizations – Medical, Psychiatric, Chemical Dependency: None

Date(s)	Reason(s)	Hospital
_____	----------	_____
_____	_____	_____