Partners for Behavioral Health and Wellness
24800 Highpoint Road, Beachwood, OH 44122
Phone: 216.342.5496 FAX: 216.763.9700

Name:_____**DOB:**_____**Date:**_____

Medications:

1. Please list all prescribed or over-the-counter medications you take along with dosages, dates prescribed and what they are taken for: **

1. Name of medication_____
   Dosage prescribed_____
   How often do you take_____
   Treatment for_____
   Start date_____ Date of last dose_____

2. Name of medication_____
   Dosage prescribed_____
   How often do you take_____
   Treatment for_____
   Start date_____ Date of last dose_____

3. Name of medication_____
   Dosage prescribed_____
   How often do you take_____
   Treatment for_____
   Start date_____ Date of last dose_____

4. Name of medication_____
   Dosage prescribed_____
   How often do you take_____
   Treatment for_____
   Start date_____ Date of last dose_____

5. Name of medication_____
   Dosage prescribed_____
   How often do you take_____
   Treatment for_____
   Start date_____ Date of last dose_____

6. Name of medication_____
   Dosage prescribed_____
   How often do you take_____
   Treatment for_____
   Start date_____ Date of last dose_____

**Please list any herbal medications or vitamins as well. If additional space is needed to list all your medications, please request another form.

Medical History:

1. Have you had any surgeries? If yes, please list with appropriate dates and reason for surgery:_____
_____
_____

2. Do you have any allergies? If yes, please list allergy, types of reaction and known start date:_____
_____
_____

3. Do you have any of the following medical problems? If yes, please indicate the date of the diagnosis or when the problem started:
____None
a. Diabetes_____
b. High cholesterol_____
c. Stroke_____
d. Seizure disorder_____
e. Hepatitis (indicate which kind)_____
f. Thyroid condition (overactive or underactive)_____
g. Respiratory (lung problems)_____
h. Heart problems (explain)_____
i. Stomach/bowel problems (explain)_____
j. Kidney/bladder problems (explain)_____
k. Neurological problems (explain)_____
l. Cancer (explain)_____
m. High blood pressure_____
n. Heart attack_____
o. HIV_____
p. Pain symptoms or conditions_____
q. Migraine headaches (how often and how severe?)_____
r. Sinus problems_____

s. Vision or hearing problems_____

t. Do you drink alcohol? Yes _____ No_____

If yes, type of alcohol, how much and how often?_____

u. Do you currently use tobacco? Yes_____ No_____

If yes, how much and how often?_____

If tobacco was used in the past, please place an X____. Start and stop dates of previous tobacco use:_____

v. Do you use recreational or illegal drugs? Yes_____ No_____

If yes, what, how much and how often?_____

w. Are you on a special diet? If yes, please explain_____

4. When was your last physical exam (best estimate)?_____

5. The following section gathers information about people in your family who may have a history of anxiety, depression, bipolar disorder, ADHD or other mental illness including drug/alcohol abuse. Please provide information for the following regarding mental illness:

Mother: Yes_____ No_____ Unknown_____
If yes, describe:_____

Father: Yes_____ No_____ Unknown_____
If yes, describe:_____

Do you have siblings? Yes_____ No_____
If yes, # brothers_____ # sisters_____
If yes, any with mental illness?
Yes____ No_____ Unknown_____

Do you have children? Yes_____ No_____
If yes, # sons_____ # daughters_____
If yes, any with mental illness?
Yes____ No_____ Unknown_____

6. Females: When was your last pap test (please indicate results)?_____
When was your last period?_____
# of pregnancies:_____
# of living children:_____
Do you use birth control? Yes_____ No_____ If yes, what kind?_____

Signature:_____ Reviewed by:_____