Assessment and Family Therapy of Northwest Ohio

Joan A. Lawrence, Ph.D., LLC

Client Medical History

Last Name: _____ First Name: _____ Date of Birth: _____

Age: _____ Primary Care Physician:_____

Who referred you to our office:_____

Name of person completing questionnaire: _____ Relationship: _____

Client Lives with: _____ Who has custody (If applicable) _____

Client's Occupation: _____ Highest Grade Completed: _____

Please specify difficulties that prompted your visit:

Age of onset of Difficulties: _____ Did the concerns suddenly appear over time: _____

What led up to these difficulties?

Medications and dosage taken on an ongoing basis:

Current legal issues with client (If any):

Has the client ever been hospitalized or had any operations? (yes) _____ (no)_____

Please list history and age:

Does the client have any allergies? (Yes) _____ (NO) _____

Please list:

Are client's problems related to an injury? (Yes) _____ (No) _____

Please specify details:

Did the accident occur while on the job? (Yes) _____ (No) _____

Was there a motor vehicle Accident? (Yes) _____ (No) _____

Is the client in litigation: (Yes) _____ (No) _____

Prior Psychological Services:

Service	Date/Age	Provider
Psychological Testing		
Psychotherapy or Counseling		
Neuropsychological Testing		
Other: List		

Please specify any other information that is pertinent to the client's care:

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Please Check all that applies:

Constitutional Symptoms	**Check**
Normal activity and Energy	
Sweating	
Change in Appetite	
Weight loss or gain	
Chills	
Fever	

Musculoskeletal	
Joint Pain/Stiffness	
Swelling	
Inflammation	
Restriction of Motion	
Atrophy	
Back Ache	

Ears, Nose and Throat	**Check**
Ringing in Ears	
Hearing Loss	
Gum Bleeding	
Nose Bleeding	
Hoarseness	
Difficulty swallowing	
Sinus congestion or pain	

Neurological	**Check**
Weakness	
Dizziness	
Speech Problems	
Touch Sensation Issues	
Gait or Balance	
Fine motor issues	
Memory	
Loss of Consciousness	
Epilepsy	
Head Injury	
Stroke	

Respiratory	**Check**
Respiratory Infections	
Shortness of Breathe	
Cough	
Wheezing	
Blood in Sputum	
Asthma	
Pnuemonia	

Gastrointestinal	**Check**
Food Intolerance	
Abdominal Pain	
Vomiting	
Nausea	
Bloating	
Chronic Diarrhea	
Chronic Constipation	
Inflammatory Bowel Disease	
Bariatric or Stomach Surgery	
Ulcers	

Cardiovascular	**Check**
Chest Pain	
Palpitations	
Fast Heart Rate	
Arrhythmia	
Shortness of Breath	
Heart Attack	
Bypass surgery	
HIgh Blood Pressure	

Psychiatric	**Check**
Anxiety	
Mood Changes	
Depression	
Problems coping with daily activities	

Eyes	**Check**
Double Vision	
Vision Changes	
Prescription Glasses	

Blood Disorders	Check
Anemia	
Easy Bruising	
Easy Bleeder	
Swollen Nodes	
HIV Positive	
AIDS	

Endocrine	Check
Thyroid Trouble	
Heat or Cold Intolerance	
Diabetes	
Excessive Thirst	
Excessive Hunger	
Excessive Urination	

Medical Conditions	Check
Cancer	
Breast Cancer	
Live Problems	
Kidney Problems	
Bladder Problems	

Other Medical Conditions (Please list):

Please indicate Service(s) Requesting:

Individual Psychotherapy

Couple Therapy

Family Therapy

Bariatric Assessment

Disability Evaluation

Psychological Evaluation

Neuropsychological Evaluation

Attention Deficit Evaluation

Consultation

Other Please List: