**CENTRE PSYCHOLOGY GROUP**
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# PSYCHOLOGICAL AND MEDICAL HISTORY SHEET

**Note: This information will remain confidential with other information in your chart**

| Name | Date of Birth |
| --- | --- |
| Date of last medical exam (month/year) | |
| Primary Care Physician (Name and Practice) | |
| Current Medical Problems (please list) | |

Check all that apply to you:

____ Neurological disorder ____ Autoimmune disorder ____ Thyroid disorder

____ Cardiovascular problems ____ Chronic pain ____ Headaches ____ Sleep disorder ____ Cancer

____ Substance use problem ____ Physical Disability ____ Seizures ____ Vision/Hearing deficit ____ Diabetes

| Current Medications (including over-the-counter and supplements) |
| --- |
| Family Medical History (note family member and illness) |
| History of Psychiatric Hospitalizations/Rehab (month/year/place) |
| Prior Counseling or Psychotherapy (date range and therapist name) |