CARY BEHAVIORAL HEALTH PC

160 N.E. MAYNARD ROAD, SUITE # 200, CARY, NC 27513
PHONE 919-466-7540 FAX 919-466-7543.

Name ____________________________________**Date**________________
Date of Birth___________ Sex_________Therapist___________________
Primary Physician:_____________________Date of Last visit____________
Psychiatrist(if applicable)______________Date of Last visit____________

TREATMENT HISTORY

Previous psychological counseling? (YES) (NO)

Facility :______________________________Date:______________________

List All Current Medications:
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Please indicate if you have or had the following conditions:

	Yes	No		Yes	No
Allergies			Nursing Difficulties		
Arthritis			Birth control problems		
Asthma/Emphysema			Infertility		
Bladder/Kidney Disease			Pap Smear		
High blood pressure			Miscarriage/Abortion		
Low Blood Pressure			Breast Masses		
Cancer			Menopause Complications		
Blood Disease			Mastectomy/Complications		
Digestive Problem			Hysterectomy/Complications		
Eye Disease			Pelvic Inflammatory Disease		
Head Injury/Pain			Prostate Disease		
Heart Disease			Seizure Disorder		
Menstrual Cramps/PMS			Sexually Transmitted Disease		
Irregular Menstrual Cycles			Skin Disease		
Break-Through Bleeding			Thyroid Disease		

Indicate Any Other Medical Condition:

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Please Complete The Reverse Side

Please Indicate If you are having or had treatment for the following conditions:

	Yes	No	Date(s) of Treatment/Location
Alcohol Abuse			
Anxiety Disorder			
Attention Deficit Disorder			
Caffeine Dependence			
Depression			
Eating Disorder			
Gambling Problem			
Learning Difficulties			
Nicotine/Smoking Problem			
Panic Attacks			
Sexual Abuse			
Sexual Assault			
Sexual Dysfunction			
Sleeping Problems			
Substance Abuse			
Other Condition			

Current Emotional Status: Please indicate if you have experienced the following during the past month.

	Seldom	Sometimes	Often
Anxiety			
Decreased Interest in Activities			
Feelings of Worthlessness			
General Unhappiness			
Irritability			
Increased Anger			
Isolation or Withdrawal			
Decision making difficulty			
Fatigue			
Concentration or memory problems			
Increased or Inconsistent Moods			

Suicidal Thought(s)____

Suicidal Attempt(s)____

Please indicate any family history of medical or psychological concerns (include physical/emotional problems, history of alcohol/substance abuse, childhood abuse history or other significant events/conditions:)

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Please indicate any other information that may assist in our treatment:

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Signature____________________Date_________