

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:

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:

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:)

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

Signature _____ Date _____