maverick
FAMILY COUNSELING

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Client Health Form

Date:

Do you have any current or ongoing medical problems or concerns?

Who is/are your primary care provider and/or psychiatrist and/or psychiatric NP?

Do you have any allergies?

Please list any medications you are currently taking (please print clearly):

Medication_____ dosage/frequency_____
Medication_____ dosage/frequency_____
Medication_____ dosage/frequency_____
Medication_____ dosage/frequency_____
Medication_____ dosage/frequency_____
Medication_____ dosage/frequency_____
Medication_____ dosage/frequency_____
Medication_____ dosage/frequency_____
Medication_____ dosage/frequency_____
Medication_____ dosage/frequency_____

Have you taken anti-depressant or anti-anxiety medications in the past? Please list.

Medication_____Date (s) of usage_____
Medication_____Date (s) of usage_____
Medication_____Date (s) of usage_____
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