Clear View Counseling and Wellness Center

4140 W. Charleston Blvd, Las Vegas, NV 89102

Medical and Psychological History Form

Section 1 – Personal History

Please check "yes" or "no" to the symptoms listed in this section if you have experienced that symptom. Remember that this section refers to you only. If you have other symptoms not listed, please inform your counselor.

Yes	No		Yes	No	
_____	_____	Depressed Mood	_____	_____	Restlessness
_____	_____	Less interest in things	_____	_____	Easily tired
_____	_____	Less pleasure in things	_____	_____	Shortness of breath
_____	_____	Loss of weight	_____	_____	Rapid heart rate
_____	_____	Weight gain/loss	_____	_____	Dizziness, lightheadedness
_____	_____	Insomnia	_____	_____	Nausea or abdominal distress
_____	_____	Early morning awakening	_____	_____	Inability to control thoughts/actions
_____	_____	Agitation	_____	_____	Being keyed up or on edge
_____	_____	Loss of energy	_____	_____	Trouble with concentration
_____	_____	Feelings of low self-esteem	_____	_____	Irritability
_____	_____	Feelings of guilt	_____	_____	Starving yourself
_____	_____	Forgetfulness	_____	_____	Food binges
_____	_____	Suicidal thoughts	_____	_____	Voluntary vomiting
_____	_____	Racing thoughts	_____	_____	Sexual problems
_____	_____	Seeing Visions	_____	_____	Multiple body pains
_____	_____	Hearing Voices	_____	_____	Problems with alcohol
_____	_____	People plotting against you	_____	_____	Problems with prescription drugs
_____	_____	Obsessions	_____	_____	Problems with street drugs
_____	_____	Feelings of being controlled	_____	_____	Hospitalized: psychiatric or drug
_____	_____	Multiple thoughts	_____	_____	Previous psychiatric care/counseling
_____	_____	Fears	_____	_____	Current couple problems
_____	_____	Panic Attacks	_____	_____	Physical, sexual, emotional abuse
_____	_____	Feelings of anxiety or nervousness	_____	_____	Uncontrollable anger

Section 2 –Brief Drug History

Past	Present		Past	Present	
_____	_____	Alcohol	_____	_____	Cocaine
_____	_____	Marijuana	_____	_____	Opiates
_____	_____	LSD	_____	_____	Inhalants
_____	_____	Methamphetamines	_____	_____	Others _____

Section 3 – Family History :

Please check "yes" or "no" to indicate whether there is a history of any of the following in your family. Please indicate who has had the problem to the right of the category

Yes	No		Yes	No	
_____	_____	Heart trouble	_____	_____	Nervous conditions
_____	_____	Diabetes	_____	_____	Depression
_____	_____	High blood pressure	_____	_____	Suicide or suicide attempts
_____	_____	Cancer	_____	_____	Sexual abuse
_____	_____	Drug or Alcohol problems	_____	_____	Dizziness, lightheadedness