GULF COAST
PSYCHOLOGICAL SERVICES, PLLC

Confidential History Questionnaire

Instructions: **Please complete this form as accurately and completely as you can.**

DEMOGRAPHICS

Date_____ Referred by Whom_____

Name_____ Date of Birth_____/_____/_____

Age_____ Gender (circle) Male/Female

Phone Number_____ Address_____

Emergency Contact_____

Handedness_____Right _____Left As a child, were you forced to change hands? YES/NO

How do you identify yourself racially/ethnically? (Please check all that apply)

____African American/Black ____South Asian

____American Indian/Alaskan Native ____Middle Eastern

____Anglo/European American/White ____Native African

____Asian/Pacific Islander ____Central or South American

_____Hispanic/Latino/Latina ____Other (please list)_____

Who completed this form?_____

CURRENT PROBLEM(S)/ILLNESS(ES)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

CURRENT MEDICATIONS/THERAPIES

Please list your current medications (or attach a list):

MEDICATION/ THERAPY	Date Started (approximate)	Prescribing Doctor	What illness is medication for?	How well is this medication working?

MEDICAL HISTORY Please describe briefly your history of past/present illnesses and treatments (including mental health treatment; i.e., depression, relationship counseling, drug rehabilitation)

Illness, disease, syndrome, issue	Dates (From-To)	Treatment (Surgery/Medication)	Facility/Physician/ Counselor Name	Current Status

Illness, disease, syndrome	Dates (From-To)	Treatment (Surgery/Medication)	Facility Name	Current Status

Significant Symptoms

Please indicate whether you have ever experiences any of the symptoms below, when, and briefly describe:

Symptom	Circle YES or NO		When it began	Briefly describe problem(s) and treatments (if any)
Loss of Consciousness	YES	NO		
Memory Difficulties	YES	NO		
Weight Changes	YES	NO		
Chronic Pain	YES	NO		
Feeling Shaky	YES	NO		
Blurred/Double Vision	YES	NO		
Changes in ability to Smell	YES	NO		
Chronic Ringing in Ears	YES	NO		