Personal / Medical Information – Tashia Amstislavski, MA, LCSW, LLC

Name_____ Date_____

Address_____

City_____ State_____ Zip_____

Phone number best to reach you:_____ OK to leave detailed messages? Yes No

Email_____ Height_____ Weight_____

Date of birth_____ Age_____ By whom were you referred?_____

For what concerns are you seeking help?_____

Are you pregnant, or think you might be pregnant? Yes No Trying to conceive? Yes No

When was your most recent physical exam?_____ Why?_____

Were there any concerns or findings of note?_____

Please describe any allergies:_____

Current health concerns: (more space available on p.2)	How long?	Previous or Current Treatment

Healthcare providers currently working with you (MDs, Psychotherapists, Naturopathic Doctors, Chiropractors, etc.):	For what issues?

Current medications, herbs, supplements	For what condition?	Prescribed by whom?

Past surgeries, major illnesses, emergency care, significant medical history	When/How long?	Kind of Treatment received?	Any remaining concerns?

Previous psychological/psychiatric/ substance abuse services?	When/ How long?	Kind of service received?	Any remaining concerns?

Substances	Frequency/pattern of use, and/or when last used? (Leave blank if none)
Alcohol	
Tobacco	
Marijuana/Hashish	
Cocaine/Crack	
Amphetamine/Crank	
LSD/Other psychedelics	
Heroin/Other opiates	
Other_____	

Please describe your dietary patterns, and any related concerns:

Please describe your exercise habits:

Please describe the concern for which you're seeking help, including specific symptoms, how long you've had the condition, what else you've done to (if anything) to address it, and anything else that seems relevant:

Please use the remaining space if you need extra room for any of the above, to tell me anything about your medical/health history you think might be important, for any additional details re: significant past or current concerns, or for anything further you feel might be helpful for me to know about you.