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MEDICAL HISTORY & GOALS FOR THERAPY

Please Print Legibly

BRIEF OVERVIEW OF MEDICAL HISTORY AND CURRENT CONDITIONS

Primary Physician _____
Clinic Name _____
Phone Number _____
Fax Number _____

1. I would describe my current health status as: (Circle one)
Excellent Good Fair Poor

2. Please list any current medical conditions or concerns:

3. Are you currently under the care of a physician (or more than one practitioner)?

4. Have you been hospitalized or had a serious illness within the past two years?
If so, please explain: _____

5. Are you presently taking any medication for medical or psychological conditions?
Please list: _____

6. Have you ever attempted suicide? If so, how long ago and did you go to a hospital?

7: Please list any alternative treatments, practitioners and supplements used currently.

8. Are there any other medical issues or concerns that you would like to tell me about?

Checklist of Concerns

Please check any present concerns or significant past concerns that still affect you:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Health | <input type="checkbox"/> Bipolar illness | <input type="checkbox"/> Gender Identity |
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Trauma | <input type="checkbox"/> Aggression | <input type="checkbox"/> Separation/Divorce |
| <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Depression | <input type="checkbox"/> Codependence | <input type="checkbox"/> Impulsiveness |
| <input type="checkbox"/> Relationships | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Alcohol/Subs Ab. | <input type="checkbox"/> Work/Career |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Sexual Orient. | <input type="checkbox"/> Family relations |
| <input type="checkbox"/> Other: (please list) _____ | | | |

Goals for Therapy

If you could get what you want from therapy, what would that be?

- 1) _____
- 2) _____
- 3) _____
- 4) _____