Michael V. Stefanovich M.D.

# Client Information Form I

**Today's Date:** _____

**A. Identification**

Your Name: _____Date of birth_____Age: _____

Home Street address: _____ Apt:_____

City:_____State_____Zip_____

Home Phone:_____E-mail:_____

**Calls or e-mail will be discreet, but please indicate any restrictions:**

_____

**A. Chief Concern**

Please describe the main difficulty that has brought you to see me:_____

_____

**B. Your Medical care**

1. Who is your primary care doctor and when was your last visit_____

_____

**If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes_____No_____**

2. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
   No____Yes_____If yes,Please indicate:

   When?_____From whom?_____

   For what?_____With what results?_____

3. Have you ever taken medications for psychiatric or emotional problems?
   No_____Yes_____If yes, please indicate:

   When?_____From whom?_____

   Which medications?_____

   For what?_____With what results?_____

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# Brief Health Information Form

**Today's Date:** _____

**Your Name:** _____

1. Describe any allergies you have:

To what?_____ Reaction you have_____

Allergy medications you take?_____

2. Do you currently have any medical problems? Have you had any medical problems in the past? Circle one:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Asthma | Current | Past | N | Diabetes | Current | Past | N |
| High Blood Pressure | Current | Past | N | Heart Disease | Current | Past | N |
| Cancer | Current | Past | N | **Other:**_____ | | | |

3. Have you done any kinds of work where you were exposed to toxic chemicals?

Date_____Kinds of chemicals?_____

Kind of work_____

Effects_____

4. Does anyone in your family suffer from psychiatric illness or see a psychiatrist?

_____

**For women only**

**1. Menstrual period experiences:**

How regular are they?_____How long do they last?_____

How much pain do you have?_____How heavy are your periods?_____

**2. Menopause:**

If your menopause has started, at what age did it start?_____

What signs or symptoms have you had?_____

_____