Deb Thompson Counseling
HEALTH INFORMATION

My present health is _____Excellent_____Good_____Fair_____Poor
Significant health concerns_____
Are you currently under the care of a physician? _____Yes _____No
If "yes" for what? _____
Physicians name_____
Current medications and supplements (prescribed or OC) you are taking, please list below.
Drug_____Dosage_____To treat?_____
Drug_____Dosage_____To treat?_____
Drug_____Dosage_____To treat?_____
Drug_____Dosage_____To treat?_____
(use this space to add more medications if needed)

Do you Smoke? _____Yes_____No Packs per day?_____ How long:_____
Do you drink alcoholic beverages? _____Yes _____No
If "yes" how much and how often?_____

Have you ever received professional counseling before? _____Yes_____No
Have you ever been hospitalized for psychiatric reasons in the past? _____Yes_____No
If "yes" when and where?_____

PHYSICIAN AUTHORIZATION

It is often helpful for your therapist to be able to consult with your physician regarding your diagnosis and treatment. Physician name_____

I give my permission for my therapist at Deb Thompson Counseling to release records and/or information about my treatment to my physician for the purpose of treatment, planning and coordinating psychotherapy with my physical health care needs. I may withdraw this consent at any time in writing or verbally by advising my therapist.

_____Yes I AUTHORIZE this release. _____No I do NOT.

Client Signature_____Date_____

Consent withdraw on_____