INITIAL MEDICAL QUESTIONNAIRE

CLEARINSIGHT PSYCHIATRY, INC.

Patient Name: _____ Age:_____ Today's Date:___/___/_____

Reason for your visit: _____

Any current stressors: _____

MEDICAL HISTORY

❑ No Existing Condition	❑ Deafness/Auditory Impairment	❑ Migraines
❑ Anemia	❑ Dermatitis or Other Skin Issues	❑ Multiple Sclerosis
❑ Arterial Sclerotic Disease	❑ Diabetes	❑ Obesity
❑ Arthritis	❑ Digestive Disorders	❑ Osteoporosis
❑ Asthma	❑ Epilepsy/Seizure	❑ Parkinson's Disease
❑ Blindness/Visual Impairment	❑ Heart Disease	❑ Stroke
❑ Cancer	❑ Hypercholesterolemia	❑ Sexually Transmitted Disease (STD)
❑ Carpal Tunnel Syndrome	❑ Hypertension	❑ Other:
❑ Chronic Pain	❑ Hypothyroidism	_____
❑ Cirrhosis		_____

CURRENT MEDICATIONS	OVER THE COUNTER SUPPLEMENTS

Any allergies to medication/food: ❑ No ❑ Yes _____

Date of your last physical examination:_____

Any past surgeries: ❑ No ❑ Yes _____

Any past trauma: ❑ No ❑ Yes _____

Any illicit drug use: ❑ No ❑ Yes _____

If you are female, do you have an irregular menstrual cycle? ❑ No ❑ Yes _____

If you are female, are you currently pregnant? ❑ No ❑ Yes