HEALTH INFORMATION

My present health is _____ Excellent _____ Good _____ Fair _____ Poor

List any significant health Concern _____

Are you currently under the care of a physician? _____ Yes _____ No

If "Yes," for what? _____

Current medications (prescription and OC) please list drug, dosage, schedule:

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Do you Smoke? _____ Yes _____ No Packs per day? _____ How Long? _____

Do you use alcoholic beverages? _____ Yes _____ NO

If "yes," how often? _____

Have you ever received or are you now receiving Family Therapy, Psychological, or Psychiatric counseling? _____ Yes _____ No

Referred by _____ Family Doctor _____

PHYSICIAN AUTHORIZATION

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

I give my permission for my therapist at DAKota Oak 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 anytime in writing or verbally by advising my therapist.

_____Yes I AUTHORIZE this release. _____ No I do NOT.

Client Signature _____ Date _____

Consent withdrawn on _____