JULIE LANG, MFT
405 W. MAIN STREET
GRASS VALLEY, CA 95945

Patient Name:_____ Date of Birth _____

Medical History

1. Present or current history and/or treatment of:

____Stroke	____Diabetes	____Tuberculosis	____Thyroid Problems
____Anemia	____Hepatitis	____Liver Damage	____Heart Problems
____Asthma	____High Blood Pressure	____Chronic Fatigue	____ Breathing Problems
____Cancer	____Migraines	____Eating or Weight Disorder	
____Seizures	____Chronic Pain	____Cardiac Problems	____Other Medical Problems
____Infectious disease			

Comments:

2. Current medication

3. Physical exam in the last year: _____ Yes _____No

   Name of Primary Care Physician:_____

   Consent for Release to Communicate with PCP if necessary? _____Yes _____No

4. Food or drug allergies? _____Yes _____No

5. Any history of psychiatric treatment or hospitalization? _____Yes _____No