

CARL L. POTTER, III LCSW

SUPPLEMENTARY INFORMATION SHEET

Name: _____ Date of Birth: _____

MEDICAL HISTORY:

Please list any significant childhood illnesses:

Please list any surgeries and when they were performed:

Have you ever had a seizure, head trauma, or loss of consciousness? _____ If so, please describe.

Have you ever had a CT scan, EEG, or MRI? _____ If so, please describe:

Have you ever been hospitalized? _____ If so, please describe.

Have you ever been seen in the emergency room? _____ If so, please describe.

If female, do you have regular menses? _____

Date of the most recent physical exam: _____

Is your vision within normal limits? _____ Is your hearing within normal limits? _____

Please list any medication and doses you are taking currently, including over-the-counter preparation, herbal preparations and vitamins.

Are you allergic to any medications? _____ If so, please list the medication and the reaction:

FAMILY HISTORY

Please list any blood relative with the following: (Specify whether on maternal side or paternal side of the family)

Substance abuse: _____

Attention deficit: _____

Learning problems or mental retardation: _____

Depression: _____

Bipolar disorder (manic-depression): _____

Schizophrenia: _____

Autism: _____

Obsessions/Compulsions: _____

Panic: _____

Eating disorders: _____

Other Anxiety: _____

Suicide: _____

Diabetes: _____

Cancer (specify type): _____

Hypertension or heart disease: _____

Thyroid disease: _____

Liver disease: _____

Kidney disease: _____

Migraines: _____

Tics: _____

Genetic syndromes (please specify): _____

Neurologic disorders (Parkinson's, multiple sclerosis, Alzheimer's, etc.): _____

Epilepsy: _____

SOCIAL HISTORY

Please list name and ages of all persons living in your home:

-
-
-
-
-
-

How do you do socially?

Recreational activities:

Any legal issues:

Do you use recreational drugs or alcohol? _____ if so, please estimate frequency and quantity of use:

PREVIOUS TREATMENT

Is this your first mental health consultation? _____ If not, please list the following where applicable:

Previous evaluations (evaluator, date of evaluation, recommendations):

Previous psychotherapy (therapist, dates of treatment):

Previous medication trials (name of medications, dose, how long the medication was taken): *Note: If uncertain, this information may be obtained from your pharmacy where prescriptions were filled.*

Previous psychiatric hospitalizations (hospital name, dates of hospitalization, treatment received during the hospitalization):

Thank you. All information will remain strictly confidential.