430 North Canal Street
Lawrence, MA 01840
978-327-6600
Fax: 978-327-6601
www.FSMV.org

Medical Record #_____

Personal Medical Record (Adult)

This form is a guide to help us understand your history so we can work more effectively with you. Some of these questions might be uncomfortable for you to answer. If that is the case, please let us know.

Name_____ DOB ____/____/____ Sex _____ Height_____ Weight _____

General Physical Health (circle one): Excellent Good Fair Poor

Current Medications (include names and dosages): _____

_____

Medication Allergies:_____

_____

Current Problems

Please check if you have any of the following problems:

	Excessive fatigue		Weight change
	Trouble sleeping		Fainting spells
	Poor appetite		Headaches
	Lack of energy		Hearing/vision
	Excessive nervousness		Serious allergies
	Dental		Hallucinations/voices
	Other:		

If you checked any of the above, please explain (for example, "I haven't been eating and I have lost 10 lbs in 3 weeks): ___

_____

_____

Are you being followed now by a physician for any reason, please explain:_____

_____

_____

Drug History

Please describe your use of: caffeine, nicotine, alcohol, prescription, street drugs, etc.

Substance	*Amount*	*How often*	*Duration*	*Currently Using?*
(Example) Cigarettes	1 pack	Daily	10 years	Yes

See Reverse Side

Client's Name_____ **DOB** _____ **Medical Record #** _____

Please explain any family history of drug or alcohol problems: _____

_____

_____

Illness/Hospitalization History

Please check if you have had any of the following:

	High blood pressure		Menstrual/hormonal
	Heart disease		Surgery
	Diabetes		Medical hospitalization
	Seizures		Psychiatric hospitalization
	Stroke		Alcohol/drug treatment
	Other:		

If you checked any of the above, please explain. Also include information on any additional medical care. _____

_____

_____

_____

_____

How many pregnancies have you had?_____
How many children have you had? _____
Have you ever experienced or caused physical abuse? _____ sexual abuse? _____

Family History

Mental Illness	*Yes*	*Which family member*
Mental Illness with hospitalization		
Suicide		
Suicide Attempts		
Serious emotional disturbance		
Substance Abuse		
Other:		

Additional medical information you feel would be helpful to us in treating you: _____

_____

_____

Please continue to next page and sign release. Thank you.

**(You do not need to sign this release in order to receive services,
but doing so allows us to best serve you.
If you have *any* questions, please speak to
your therapist)**

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Client's Name_____ DOB _____ Medical Record # _____

MEDICAL RELEASE

I _____ give permission to Family Services to request current medical information for the purpose of diagnostic evaluation and treatment planning from, and release information to, my Primary Care Physician.

This authorization expires one year from the date I signed this document unless otherwise noted. I can revoke this authorization with a written signed request at any time, except to the extent that information has already been released or received while acting in reliance on this authorization. I am not required to sign this authorization to receive services, unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPPA privacy rule. Information received by Family Services from another source cannot be released to anyone. I understand that Federal Regulation 42 CFR, Part 2, protects any drug/alcohol information that I authorize to be released. Finally, I understand that Family Services is released from all legal responsibility that may arise out of this signed permission to release my personal health information.

This authorization is voluntary and made according to my directions.

Client Signature_____Date _____

Legal guardian _____Date _____

Therapist Signature _____Date_____

***Primary Care Physician Name:_____**

***Primary Care Physician's Address:_____**

_____

***Primary Care Physician's Phone Number:_____**

***In order to better serve you, please fill this form out completely. Thank you.**