

# **Journey.....counseling and consultation**

## **Medications/Medical History**

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_

*Please answer the following as it applies to the client*

**Name of Primary Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

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**Phone:** (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

**Please note any major medical problems present in client's family history:**

**Please note any past/current major medical problem for the client (note date of treatment if any):**

**Please note any allergic and/or sensitive reactions to any medication:**

**Please note any medications that have been taken within the past six (6) months which are not currently being taken (indicate reason, duration, and reason for discontinuing):**

**[On the reverse side please record all current medications being used]**

**Medication**

**Purpose**

**Dosage**

**Prescribing Physician**