JULIE LANG LMFT
405 W MAIN STREET
GRASS VALLEY, CA 95945

Patient Name: _____ Date of Birth: _____

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 ____Cardiac Problems ____Seizures

____Chronic Pain ____ Infectious Disease ____Eating or Weight Disorder

____Other Medical Problems

Comments:

2. Current medications

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 If yes, please explain _____

   _____

5. Any history of psychiatric treatment or hospitalization? _____ Yes _____ No

   If yes, please explain _____

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