

**PORTLAND DIALECTICAL BEHAVIOR THERAPY PROGRAM, PC
5200 SW MACADAM AVE SUITE 580 PORTLAND, OREGON 97239**

PHONE: (503) 231-7854

FAX: (503) 231-8153

MEDICAL INFORMATION FORM

Client Name: _____ Date: _____

Height: _____ Weight: _____ Age: _____

Please write down the following information in the space provided.

1. General medical illnesses that I have or have had (for example: cancer, arthritis, heart, thyroid, neurological diseases, infectious conditions, or other illnesses such as migraines, fibromyalgia, etc.)

2. Prescriptions or over-the-counter medicines that I take regularly.

3. Allergies that I have to foods, medicines, etc.

4. General medical illnesses that run in my family (such as diabetes, heart disease, and others.)

5. Other notes about my health.
