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Client's Family History
[Parent(s) complete for minor clients]

Please check if you or anyone in your family (parents, siblings, children, aunts, uncles, cousins, grandparents) has had or has any of the following conditions:

	<u>Client</u>	<u>Family</u>
Alcoholism or Problems with Alcohol	_____	_____
Allergies	_____	_____
Anorexia/Bulimia/Disordered Eating	_____	_____
Anxiety	_____	_____
Arthritis	_____	_____
Asthma	_____	_____
Bipolar Mood Disorder	_____	_____
Cancer	_____	_____
Depression	_____	_____
Developmental Disability	_____	_____
Diabetes	_____	_____
Drug Abuse	_____	_____
Heart Disease	_____	_____
High Blood Pressure	_____	_____
Immune Diseases	_____	_____
Irritable Bowel Disease	_____	_____
Legal Issues	_____	_____
Liver Problems	_____	_____
Multiple Sclerosis	_____	_____
Obsessions or Compulsions	_____	_____
Phobias	_____	_____
Physical Abuse	_____	_____
Physical Disability	_____	_____
Psychiatric Hospitalization	_____	_____
Seizures	_____	_____
Self-harm	_____	_____
Sexual Abuse	_____	_____
Sleep Problems	_____	_____

Other Medical or Psychological Problems (describe what and for whom):
