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Client Health Information

Date: ____________________

Reason for appointment: ____

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Past Psychiatric Treatment (hospitalizations, outpatient counseling/treatment, substance treatment) : ____

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Family History of Mental Health/Suicide/Substance Treatment:

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Drug Allergies: _________________________________Height: ________ Weight: ________

All Current medications (Include medicine name, dosage, how often and how long taken):

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Chronic Medical Concerns:

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Past Surgeries/Hospitalizations: ____

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Medical Review of Symptoms

Active Medical Problems: Please indicate yes or no, circle all that apply, provide details

General	Yes___ No___	fatigue, weight change, skin problems
Eyes/ears	Yes___ No___	vision problems, hearing problems
Nose/throat	Yes___ No___	nose bleeds, colds, sinus allergies, swallowing problems
Cardiovascular	Yes___ No___	chest pain, fainting, palpitations, high blood pressure
Respiratory	Yes___ No___	shortness of breath, asthma, cough, wheezing
Gastrointestinal	Yes___ No___	nausea, vomiting, constipation, diarrhea, pain, bloating
Genitourinary	Yes___ No___	urgency, frequency, incontinence, UTIs, sexual problems
Muscular	Yes___ No___	pain, weakness, stiffness, joint problems
Neurological	Yes___ No___	seizures, tremors, headaches, memory, speech problems
Endocrine	Yes___ No___	diabetes, hormonal issues, thyroid problems
Blood/Lymph	Yes___ No___	anemia, bleeding/bruising tendency

Details:

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