Client Health Information

Date: _____

Reason for appointment: _____

_____

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

_____

_____

Family History of Mental Health/Suicide/Substance Treatment:

_____

_____

Drug Allergies: _____Height: _____ Weight: _____

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

_____

_____

_____

Chronic Medical Concerns:

_____

_____

Past Surgeries/Hospitalizations: _____

_____

Medical Review of Symptoms

Active Medical Problems: Please indicate yes or no

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:

_____

_____