Associates In Mental Health Administrative Office – 360-715-2488 FAX 360-671-1842

MEDICAL HISTORY

Client's Name _____ Date form completed _____

Client's DOB _____ Form completed by: _____

Client's Primary Care Physician: _____

List all doctors or medical specialists the client sees now or has seen in the past year

1. _____
2. _____
3. _____

Date of client's last physical exam _____ Examiner's name _____

Describe any current medical problems or recent changes in client's physical condition: _____

_____

What is client's Height? _____ How is client's appetite? []good [] fair [] poor
Weight? _____ How well does client sleep? []good [] fair [] poor
Is client gaining weight? [] yes [] no How is energy level? []good [] fair [] poor
Is client losing weight? [] yes [] no Rate client's general health [] good [] fair [] poor
If yes, amount of gain [] loss [] _____ lbs. Date gain/loss began _____

List any hospitalizations:
1. _____
2. _____

List all medications client is taking. Include non-prescription drugs and health supplements.

Drug Name	Dosage	# Per Day	Drug Name	Dosage	# Per Day
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Do you have any allergies to medication? [] yes [] no If yes, which ones? _____

Check any of the following which you use or have used:

Substance	used in Past	use Now	problem Now	how much/ Often	Substance	used in Past	use Now	problem Now	how much/ Often
Hard Liquor					Barbiturates				
Beer/Wine					Cocaine				
Marijuana					Tobacco				
Speed/Amphet.					Coffee				
Heroin					Soft Drinks				
L.S.D.					Other				

Further comments on alcohol or drug use: _____
_____
_____
_____

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Client Name: _____

Has client had any previous mental health treatment or counseling? [] yes [] no If yes, describe below:

Dates Location or therapist Reason for seeing therapist .

_____.

_____.

Further comments on mental health care results and/or reasons for termination:

_____

_____

Check any of the following symptoms you (the client) have had in the past three months:

X symptom	X symptom	X symptom	X symptom
[] Vision	[] Weakness in arms or legs	[] Constipation	[] Chronic pain
[] Hearing loss	[] Convulsion/Seizures	[] Diarrhea	[] Back pain
[] Headaches	[] Nausea or vomiting	[] Stomach aches	[] Menstrual Irregularities
[] Fainting	[] Shortness of breath	[] Unusual bleeding	[] _____
[] Dizziness	[] Chest pains or tightness	[] Abnormal growth or lump	
[] Head injury	[] Loss of consciousness	[] Memory loss	

Check any of the following conditions you (the client) has had and give dates of onset.

X condition	Date	X condition	Date	X condition	Date
[] Allergies		[] Fibromyalgia		[] Liver problems	
[] Anemia		[] Glaucoma		[] Low blood pressure	
[] Angina		[] Gonorrhea		[] Lung condition	
[] Arthritis		[] Gout		[] Migraines	
[] Asthma		[] Head trauma		[] Multiple sclerosis	
[] ADD		[] Heart disease		[] Obesity	
[] Autism		[] Hepatitis		[] Parkinson's disease	
[] Birth defects		[] High blood pressure		[] Polio	
[] Bladder problems		[] Huntington's chorea		[] Rheumatic Fever	
[] Bowel problems		[] Hyperactivity		[] Stomach ulcers	
[] Cancer		[] Hypoglycemia		[] Stroke	
[] Cerebral Palsy		[] Hysterectomy		[] Syphilis	
[] Chronic Fatigue		[] Jaundice		[] Thyroid disease	
[] Circulation problems		[] Kidney problems		[] Tuberculosis	
[] Diabetes		[] Learning disability		[] AIDS/HIV +	
[] Epilepsy		[] Leukemia		[] Other _____	

Please indicate if any of the client's blood relatives (mother, father, grandparent, sister, brother, etc.) have had any of the above conditions. _____

_____

Have any of the client's blood relatives had any of the following conditions? Indicate who.

X condition	who	X condition	who
[ ] Alcohol/drug abuse	_____	[ ] Nervous breakdown	_____
[ ] Anxiety or Panic Disorder	_____	[ ] Obsessive/Compulsive Disorder	_____
[ ] Attention Deficit Disorder	_____	[ ] Psychiatric Hospitalization	_____
[ ] Bipolar Illness	_____	[ ] Schizophrenia	_____
[ ] Depression	_____	[ ] Seizure Disorder	_____
[ ] Dementia	_____	[ ] Suicide	_____

Additional comments on client's health or client's family health history: _____

_____