Associates In Mental Health Administrative Office *(360) 715 - 2488 Phone*
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MEDICAL HISTORY

Client Name:_____ **Date**:_____/_____/_____

Date of Birth: _____/_____/_____ Form completed by: [ ] self [ ] parent [ ] guardian [ ] spouse/equivalent

Primary Care Physician:_____

Please 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**: _____

Client's Height: _____ **Client's Weight**:_____ **Is client gaining/losing weight?** [ ] yes [ ] no
If yes, amount of gain [ ] _____ loss [ ] _____ Date gain/loss began:_____

List any prior hospitalizations:
1._____
2._____
3._____

How is client's appetite? [ ] good [ ] fair [ ] poor. **How well does client sleep?** [ ] good [ ] fair [ ] poor.
How is client's energy level? [ ] good [ ] fair [ ] poor.
Rate client's general health: _____

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

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

Drug Name	Dosage	# Per Day	Drug Name	Dosage	# Per Day

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

Check any of the following which you use/have used and how much/often:

Substance	Past	Now	How Much/Often	Substance	Past	Now	How Much/Often
Hard Liquor				Barbiturates			
Beer/Wine				Cocaine			
Cannabis				Tobacco			
Amphetamines				Coffee			
Heroin				Soft Drinks			
LSD				Other			

Further comments on alcohol or drug use including problem use/abuse: _____
_____
_____
_____

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

Location/Therapist	Dates	Reason

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:

[ ] Vision [ ] Weakness in arms or legs [ ] Constipation [ ] Diarrhea [ ] Stomach aches [ ] Unusual bleeding [ ] Abnormal Growth or Lump [ ] Memory Loss [ ] Chronic Pain [ ] Back Pain [ ] Menstrual Irregularities [ ] Hearing loss [ ] Convulsion/Seizures [ ] Headaches [ ] Nausea or Vomiting [ ] Fainting [ ] Shortness of Breath [ ] Dizziness [ ] Chest Pains or Tightness [ ] Head Injury [ ] Loss of Consciousness
Dates for above: _____

Check any of the following conditions you (the client) have had and give dates of onset:

Condition	Date	Condition	Date	Condition	Date
[ ] Allergies		[ ] Epilepsy		[ ] Learning Disability	
[ ] Anemia		[ ] Fibromyalgia		[ ] Leukemia	
[ ] Angina		[ ] Glaucoma		[ ] Parkinson's	
[ ] Arthritis		[ ] Gonohhrea		[ ] Polio	
[ ] Asthma		[ ] Gout		[ ] Rheumatic Fever	
[ ] Attention Deficit		[ ] Head Trauma		[ ] Stomach Ulcers	
[ ] Autism		[ ] Heart Disease		[ ] Stroke	
[ ] Birth Defects		[ ] Hepatitis		[ ] Syphilis	
[ ] Bladder Problems		[ ] High Blood Pressure		[ ] Thyroid Disease	
[ ] Bowel Problems		[ ] Huntington's Chorea		[ ] Tuberculosis	
[ ] Cancer		[ ] Hyperactivity		[ ] AIDS/HIV	
[ ] Cerebral Palsy		[ ] Hypoglycemia		Other	Date
[ ] Chronic Fatigue		[ ] Hysterectomy		[ ]	
[ ] Circulation Problems		[ ] Jaundice		[ ]	
[ ] Diabetes		[ ] Kidney Problems		[ ]	

Please indicate which/whom 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?

[ ] Alcohol/drug abuse [ ] Anxiety or Panic Disorder [ ] Attention Deficit/Hyperactivity Disorder [ ] Bipolar Disorder [ ] Depression [ ] Dementia [ ] Nervous breakdown [ ] Obsessive/Compulsive Disorder [ ] Psychiatric Hospitalization [ ] Schizophrenia [ ] Seizure Disorder [ ] Suicide
Indicate which/whom: _____
_____

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