PATIENT HEALTH DATA

Name: _____ Birth Date: _____ Age: _____ Sex: M / F Parent/Guardian _____

Current Medical Concerns/treatment_____

Physician _____Date of last physical: _____

Do you currently take any nutritional supplements? _____ Please describe_____

Please list all current medications. Include over the counter medications. (**Use back of form if more space is needed).**

Medications	**Date Started**	**Purpose**	**Prescribed by**

Health history (Please underline the conditions that apply and circle the ones' that are current)

History of physical abuse	Y	N	Recent loss/death in family	Y	N
History of sexual abuse	Y	N	Change in Appetite	Y	N
Psychological abuse	Y	N	Stomach Ulcers	Y	N
Thyroid Problem	Y	N	Stroke	Y	N
Fainting	Y	N	High Blood Pressure	Y	N
Shortness of breath	Y	N	Chest Pain	Y	N
Cancer	Y	N	Divorce	Y	N
Liver Disease	Y	N	Motor Difficulties	Y	N
Sleep Difficulties	Y	N	Head Injury	Y	N
Seizures	Y	N	Loss of consciousness	Y	N
Nausea/vomiting	Y	N	Bed wetting	Y	N
Blood Disease	Y	N	Recurring headaches	Y	N
Vertigo/dizziness	Y	N	Any Other Concern?	Y	N
Skin Ulcers/lesions	Y	N	Pregnant	Y	N

Prior Psychiatric/psychological treatment

Psychiatric hospitalizations: (dates and reason) _____

Prior psychiatrists: (dates) _____

Prior therapists: (dates) _____

Drug use: If yes **please note date of last use**.

Smoke Y N (How many packs per day? _____ If quit when_____

Alcohol Y N (How much/how often? _____ Have you consumed **alcohol** in the past 24 hours? _____

Cocaine Y N (How much/how often? _____ LSD Y N (How much/how often? _____

PCP Y N (How much/how often? _____ Stimulants Y N (How much/how often? _____

Marijuana Y N (How much/how often? _____ Caffeine Y N (How much/how often? _____

Family History:

Nervous or mental illness If yes, who_____

Alcohol or drug use If yes, who _____

Diabetes If yes, who _____

List known allergies: _____

List serious medication side effects: _____

This medical history is complete and correct based on my knowledge. I authorize the release of any medical information necessary and authorize payment of medical benefits to the provider from my insurance carrier.

_____ _____ _____

Signature of Client If minor Guardian Signature Date