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______________________________________

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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)

Condition			Condition		
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