HEALTH HISTORY

NAME _____ AGE ____ DATE OF BIRTH _____ DATE _____
Signature

Have you ever had or been treated for the following conditions? (Please check)

Allergies	[ ]	Blood Disease	[ ]	Hi Blood Pressure	[ ]	Back Trouble	[ ]
Hay Fever	[ ]	Cancer	[ ]	Heart Disease	[ ]	Arthritis	[ ]
Asthma	[ ]	Diabetes	[ ]	Kidney Disease	[ ]	Chronic Pain	[ ]
Emphysema	[ ]	Low blood sugar	[ ]	Bladder Problems	[ ]	Headaches	[ ]
Skin Problems	[ ]	Thyroid Problems	[ ]	Prostate Disease	[ ]	Injury/Fracture	[ ]
Constipation	[ ]	Liver Disease	[ ]	Menstrual Problem	[ ]	Epilepsy/seizure	[ ]
Stomach Problems	[ ]	Hearing Problems	[ ]	Abortion/Miscarry	[ ]	Eating Disorder	[ ]
Irritable Bowel	[ ]	Vision Problems	[ ]	Sexual Problems	[ ]	Drinking Problem	[ ]
Weight Problems	[ ]	Dental Problems	[ ]	Sleep Problems	[ ]	Drug Abuse	[ ]

Please list any hospitalizations (dates and reasons): _____

_____

_____

Please list all prior mental health services received:

With Whom?	Year?	How Long?	For What?

Are there any physical problems in the family that concern you?

Are there any emotional problems in the family that concern you?

Have you ever been physically abused [ ] or sexually molested [ ]?

Are you currently under the care of a doctor for any physical or emotional condition? ____
If so, please list doctor's name, reason for treatment, date last seen: _____

_____

Current medications you are taking (list all, even non-prescription & occasional):

_____

Current Health Concerns: Please check any area where you think you may have a problem:

Hearing/Vision	[ ]	Anxiety/Nervousness	[ ]	Interpersonal Relationships	[ ]
Speech	[ ]	Depression	[ ]	School Problems	[ ]
Dental Health	[ ]	Anger or temper	[ ]	Work/Job/Career Problems	[ ]
Breathing	[ ]	Frequent Mood Changes	[ ]	Marital Problems	[ ]
Circulation	[ ]	Guilt	[ ]	Parenting Skills	[ ]
Digestion	[ ]	Self-Concept	[ ]	Sexuality	[ ]
Bowel Function	[ ]	Tiredness/Fatigue	[ ]	Problems with Relatives	[ ]
Urinary Function	[ ]	Sleep Disturbances	[ ]	Legal (lawsuit, charges)	[ ]
Joint/Muscle Function	[ ]	Suicide ideas	[ ]	Exercise, Hobbies	[ ]
Skin Condition	[ ]	Indecision	[ ]	Drinking Problem	[ ]
Pain	[ ]	Memory/Concentration	[ ]	Drug Problem	[ ]
Menstrual Cycle	[ ]	Eating/Appetite	[ ]	Behavior Problems	[ ]
Menopause	[ ]	Weight loss/gain	[ ]	Other _____	[ ]
Smoking	[ ]	Phobias	[ ]	_____	[ ]

Name of Physician seen in the past 12 months: _____