PHYSICAL HEALTH HISTORY

______________________________ _______ ______________________________
Client Name (last, first) Date of Birth

General Health (Circle One) Excellent Good Fair Poor

Sleep Problems (Circle One) None Occasional Frequent

Recent change in sleep pattern or quality? Y N

Describe:____

Appetite: (Circle One) Excellent Good Fair Poor

Recent change in appetite? Y N

Recent Gain or Weight Loss? Y N

Was this recent weight gain or loss intentional? Y N
____

Please check below if you currently have any of these symptoms?

__Severe Headaches
__High/Low Blood Pressure
__Shortness of Breath
__Asthma/Chronic Cough
__Difficulty Concentrating
__Abdominal Pain/Indigestion
__Nausea/Vomiting
__Numbness/Tingling
__blurred vision
__Heart Pounding
__Dizziness/fainting
__Chest Pain/Pressure
__Nose Bleeds
__Severe Injury
__Back Injury
__Hearing Trouble
__Loss of Memory

If yes, please explain:
____
____
____

Personal or Family History Of:
__Cancer
__Heart Disease
__Diabetes
__TB
__Thyroid Problems
__Other ____________

Major Surgeries or Injuries/year:
____

____

Head Injuries: Yes/No

If yes, please provide a brief summary of injury, including age at which it occurred:
____

____

Name of your primary care physician?______________________________Ph#______________

Date last seen by physician_____________________

Current medications you are taking, including dosage:

Name of medication — Dosage

____

____

____

Please check below any that apply to you:

cigarettes_____	# Packs per day______	For how long?_______
Alcohol____	Amount per week_____	For how long?_______
Coffee____	# Cups per day_______	For how long?_______

Exercise____ Describe____

Has anyone ever suggested to you that you were/are dependent on alcohol or other drugs? ____Yes ____No

Are you currently using alcohol or other drugs? ____ Yes ____No

If "yes" list all substances

____

If this use was in the past, when did you stop?______________________________________

Have you ever received mental health services? ____Yes ____No

Have you ever received substance abuse services? _____ yes _____ no

In-Patient

When?____

Where?____

Out-Patient

When?____

re?____

Have you ever been a victim of emotional, physical, or sexual abuse? Y N

____

____

FAMILY HISTORY: Please tell us if anyone in your family has a history of:

Mental Health disorder ____

____

Substance use ____

____

This information is correct to the best of my knowledge.

________________________ ________________________
Client Signature Date