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**CLIENT’S HEALTH HISTORY**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| Height:  Weight: | Name of family physician(s) & contact information: | Name of specialty physician(s) & contact information: | Do you require any accommodations or have any special needs: Yes / No  Explain: |
| **Check all that apply to your current health status** | | | | |
| |  |  |  | | --- | --- | --- | | 🞎 High Blood Pressure | 🞎 Seizures | 🞎 Chronic Pain | | 🞎 High Cholesterol | 🞎 Parkinson’s disease | 🞎 Fractures | | 🞎 Chest Pain | 🞎 Alzheimer’s disease/Dementia | 🞎 Arthritis | | 🞎 Coronary Artery Disease | 🞎 Headaches/Migraines | 🞎 Osteoporosis | | 🞎 Stents | 🞎 Stroke |  | | 🞎 Heart Attack |  |  | |  |  |  | | 🞎 Diabetes, type 1 | 🞎 Cirrhosis | 🞎 Allergies | | 🞎 Diabetes, type 2 | 🞎 GERD | 🞎 Psoriasis | | 🞎 Hyperthyroidism | 🞎 Acid Reflux | 🞎 Sinusitis | | 🞎 Hypothyroidism | 🞎 Hepatitis/Liver problems |  | |  |  |  | | 🞎 Asthma | 🞎 Blood transfusion | 🞎 Weight problems | | 🞎 Chronic Bronchitis | 🞎 Iron Deficiency | 🞎 Vision problems | | 🞎 COPD | 🞎 HIV/AIDS | 🞎 Cancer Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 🞎 Sleep Apnea | 🞎 Bleeding/Bruising | 🞎 Tuberculosis | | 🞎 Breathing Problems |  | 🞎 Urinary/Kidney Problems | | | | | |
| Other: | | | | |
| Are you pregnant? 🞏 Yes 🞏 No If yes, name of prenatal care provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| **Problem Categories** | | | | | | |
| 🞎 ADHD | | 🞎 Borderline Personality Disorder | | | 🞎 Family Violence | |
| 🞎 Alcohol | | 🞎 Depression | | | 🞎 Grief | |
| 🞎 Another Person’s Alcohol or Drug Problem | | 🞎 Drug | | | 🞎 Legal | |
| 🞎 Another Person’s Emotional or Physical Health | | 🞎 Eating Disorder | | | 🞎 Marital | |
| 🞎 Anxiety | | 🞎 Emotional | | | 🞎 Obsessive Compulsive | |
| 🞎 Oppositional Defiant Disorder | | 🞎 Schizophrenia | | | 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 🞎 Bipolar Disorder | | 🞎 Family | | |  | |
| **Current Medications:** | **Dosage** | | **Frequency** | **Prescriber** | | **Helpful?**  **(Yes or No)** |
| *Prescriptions:* |  | |  |  | |  |
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| *Over the Counter:* |  | |  |  | |  |
| *Homeopathic:* |  | |  |  | |  |
| Please list any medical allergies and/or adverse reactions to medication:  Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

Refer To: Operations Policies and Procedures: 6.3.2 Admissions Client#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7/14, 2/15, 6/18, 2/19