****

**CLIENT’S HEALTH HISTORY**

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

|  |  |  |  |
| --- | --- | --- | --- |
| 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 / NoExplain: |
| **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **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:* |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| *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