Southwest Counseling Service

ENRICHING LIVES THROUGH WELLNESS, RECOVERY & HOPE

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 / No Explain: ☐ ☐

Check all that apply to your current health status

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Chest Pain
- ☐ Coronary Artery Disease
- ☐ Stents
- ☐ Heart Attack
- ☐ Seizures
- ☐ Parkinson's disease
- ☐ Alzheimer's disease/Dementia
- ☐ Headaches/Migraines
- ☐ Stroke
- ☐ Chronic Pain
- ☐ Fractures
- ☐ Arthritis
- ☐ Osteoporosis

- ☐ Diabetes, type 1
- ☐ Diabetes, type 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Cirrhosis
- ☐ GERD
- ☐ Acid Reflux
- ☐ Hepatitis/Liver problems
- ☐ Allergies
- ☐ Psoriasis
- ☐ Sinusitis

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Breathing Problems
- ☐ Blood transfusion
- ☐ Iron Deficiency
- ☐ HIV/AIDS
- ☐ Bleeding/Bruising
- ☐ Weight problems
- ☐ Vision problems
- ☐ Cancer Type _____
- ☐ Tuberculosis
- ☐ Urinary/Kidney Problems

Other:

Are you pregnant? ☐ Yes ☐ No If yes, name of prenatal care provider_____

Problem Categories

- ☐ ADHD
- ☐ Alcohol
- ☐ Another Person's Alcohol or Drug Problem
- ☐ Another Person's Emotional or Physical Health
- ☐ Anxiety
- ☐ Oppositional Defiant Disorder
- ☐ Bipolar Disorder
- ☐ Borderline Personality Disorder
- ☐ Depression
- ☐ Drug
- ☐ Eating Disorder
- ☐ Emotional
- ☐ Schizophrenia
- ☐ Family
- ☐ Family Violence
- ☐ Grief
- ☐ Legal
- ☐ Marital
- ☐ Obsessive Compulsive
- ☐ Other _____

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

Client#:_____