

Adult Medical History Form

(Age 16 and Older)

Directions: Please answer the following questions to the best of your knowledge.

| CLIENT INFORMATION | | | | |
|--|---|--|---|--|
| Last Name | First Name | Middle | Primary Language | Social Security No. |
| Street Address | City | State | Zip | OK to Send Letter? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Home Phone | OK to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No | Work Phone | OK to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Date of Birth | Marital Status: <input type="checkbox"/> Single without partner <input type="checkbox"/> Single with partner Length of Time: _____ <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | | |
| Children: <input type="checkbox"/> Yes <input type="checkbox"/> No | How Many? | Number of Persons Living in Your Home? | | Race/ Ethnicity |
| Emergency Contact Person | | Phone Number | Relationship | |

| PRIMARY PHYSICIAN(S) | | |
|----------------------|---------|---------|
| Name | Name | Name |
| Address | Address | Address |
| | | |
| | | |
| Phone: | Phone: | Phone: |

Medication Allergies? Yes No

If yes, what medication(s) _____

Substance or Food Allergies? Yes No

If yes, what substance(s) _____

FAMILY HISTORY: Please check the box if your family has a history of:

- | | | | | |
|-----------------------------------|--|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack, Heart Disease | <input type="checkbox"/> Blood Clots or Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Family History Unknown | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Epilepsy/Seizure |

Any other major conditions? _____

If you answered yes to any of the above, please explain: _____

Are you currently being treated for medical conditions? Yes No If yes, please list: _____

MEDICATIONS (List more on separate page if necessary)

| Current Medications | For what condition? | Dosage | Frequency | Date started | Comments / Problems / Concerns |
|---------------------|---------------------|--------|-----------|--------------|--------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Past Medications / For what condition? (List sedatives, pain medications, sleeping pills, antidepressants, etc)

| | | | | |
|--|--|--|--|--|
| | | | | |
| | | | | |

Social/Sexual Risk History

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you smoke? If yes, how many cigarettes per day? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you use alcohol? If yes, how often, how much? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever had or would you like help now with an alcohol or drug problem? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Would you like to discuss problems related to a rape or emotional/physical/sexual abuse? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you now or have you ever been in a relationship where you have been physically hurt or threatened? |

Client Name: _____

DOB: _____

Healthy Mind Counseling Services, Inc.

| REVIEW OF SYSTEMS: Please check the box if you currently have or have ever had the following | | | |
|---|--|---|--|
| 1. General | | | |
| Productive cough (3 weeks or more) | <input type="checkbox"/> Current <input type="checkbox"/> Past | Unusual discharge (vaginal or from penis) | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Dry, unproductive cough (3 wks or more) | <input type="checkbox"/> Current <input type="checkbox"/> Past | Bloody or painful urination | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Shortness of breath | <input type="checkbox"/> Current <input type="checkbox"/> Past | Dark, bloody or painful bowel movements | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Chest pain | <input type="checkbox"/> Current <input type="checkbox"/> Past | Hepatitis A | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Recurrent night sweats, chills, fevers | <input type="checkbox"/> Current <input type="checkbox"/> Past | Hepatitis B | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Swollen glands (neck, armpits or groin) | <input type="checkbox"/> Current <input type="checkbox"/> Past | Hepatitis C | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Persistent weight loss without dieting | <input type="checkbox"/> Current <input type="checkbox"/> Past | Chronic Fatigue | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Weight problem/eating disorder | <input type="checkbox"/> Current <input type="checkbox"/> Past | Cancer | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Tuberculosis: Ever Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Date and result of last test: _____ | If Positive, did you have a chest x-ray? _____ |
| Ever Treated? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Date(s) and type(s) of treatment: _____ | |
| HIV: Ever Tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Would you like information regarding HIV/AIDS or testing sites? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

| REVIEW OF SYSTEMS: Please check the box if you currently have or have ever had the following: | | | |
|---|--|--|--|
| 2. Skin | | 7. Gastrointestinal | |
| Allergies/Rash/Itching | <input type="checkbox"/> Current <input type="checkbox"/> Past | Recurrent nausea/vomiting/diarrhea | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Psoriasis / Eczema | <input type="checkbox"/> Current <input type="checkbox"/> Past | Stomach/bowel problems | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| | | Gall bladder disease | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| 3. Eyes | | Pancreatitis | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Vision problems | <input type="checkbox"/> Current <input type="checkbox"/> Past | Diabetes / hyperglycemia / hypoglycemia | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Eye infections | <input type="checkbox"/> Current <input type="checkbox"/> Past | Encopresis (incontinent of feces) | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| 4. Ears, Nose, Throat, Lungs | | 8. Genitourinary | |
| Hearing problems | <input type="checkbox"/> Current <input type="checkbox"/> Past | Bladder/kidney problems or infection | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Teeth/gum problems or disease | <input type="checkbox"/> Current <input type="checkbox"/> Past | Incontinence (unable to control bladder) | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Frequent nosebleeds | <input type="checkbox"/> Current <input type="checkbox"/> Past | Enuresis (bedwetting) | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Recurrent sinusitis | <input type="checkbox"/> Current <input type="checkbox"/> Past | Sexually transmitted diseases: | |
| Frequent sore throats | <input type="checkbox"/> Current <input type="checkbox"/> Past | Gonorrhea Syphilis Herpes | |
| Recurrent Pneumonia | <input type="checkbox"/> Current <input type="checkbox"/> Past | Chlamydia Trichomonas | |
| Asthma | <input type="checkbox"/> Current <input type="checkbox"/> Past | HPV or genital warts | |
| 5. Cardiac | | Females: | |
| Palpitations/arrhythmia | <input type="checkbox"/> Current <input type="checkbox"/> Past | Menstrual Difficulties | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Heart disease/murmur | <input type="checkbox"/> Current <input type="checkbox"/> Past | Cycle: Regular Irregular | |
| High blood pressure / Low blood pressure | <input type="checkbox"/> Current <input type="checkbox"/> Past | Pre-Menopause Menopause | |
| High cholesterol | <input type="checkbox"/> Current <input type="checkbox"/> Past | Problems/infection of tubes/ovaries/uterus | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Thrombophlebitis/blood clots | <input type="checkbox"/> Current <input type="checkbox"/> Past | Abnormal Pap Smear(s) | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| 6. Neurological | | Number of pregnancies | |
| Stroke | <input type="checkbox"/> Current <input type="checkbox"/> Past | Number of births | |
| Frequent Headaches or Migraines | <input type="checkbox"/> Current <input type="checkbox"/> Past | Problems with pregnancies/births (explain) | |
| Seizures/Epilepsy | <input type="checkbox"/> Current <input type="checkbox"/> Past | Breast disease / tumor / surgery (explain) | |
| Weakness/paralysis/unsteady walking | <input type="checkbox"/> Current <input type="checkbox"/> Past | | |
| Dizziness/confusion/wandering | <input type="checkbox"/> Current <input type="checkbox"/> Past | Miscellaneous: | |
| Forgetfulness/memory lapse/memory loss | <input type="checkbox"/> Current <input type="checkbox"/> Past | Anemia / blood disorder | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Other conditions / problems not listed: | | Arthritis | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| | | Sleep disturbance | <input type="checkbox"/> Current <input type="checkbox"/> Past |

I certify that I have answered these questions to the best of my knowledge

Client Signature: _____ Date: _____

CLINICIANS NOTES (CLARIFICATIONS / FOLLOW UP / ETC)

Reviewed by (Clinician): _____

Date: _____

Client Name: _____

DOB: _____

Rev. 2/11