ASSURANCE COUNSELING, LLC.

MEDICAL HISTORY FORM ID#_____

PARENT TO COMPLETE ON BEHALF OF CHILD, IF CLIENT IS CHILD

Client's Name: _____ Age _____ Date Completed_____

Client's Height: _____ Weight: _____

1. **Allergies to drugs or other items: No____ Yes____ (Specify)_____**
2. **Seizures: No____ Yes____ (Specify)_____**
3. **Recent loss of consciousness: No_____ Yes_____ (Specify)_____**

   When did they start?_____
4. **Any history of overdose of drugs or withdrawal symptoms: No_____ Yes_____**

   (Specify/Describe):_____
5. **Recent vomiting, constipation, and/or diarrhea: No_____ Yes_____ (Specify)_____**

   _____
6. **Any history of black-outs: No_____ Yes_____ (Specify)_____**
7. **Recent tremors: No_____ Yes_____ (Specify)_____**
8. **Any of the following illnesses or conditions: No_____ Yes_____**
   If yes, please circle and state treatment received, with what doctor, and date(s) of treatment:

Diabetes	**Asthma**	**Heart Trouble**	**High Blood Pressure**
Cancer	**Kidney Disease**	**Tuberculosis**	**Arthritis**
Pneumonia	**Ulcers**	**Jaundice**	**Rheumatic Fever**
Epilepsy	**AIDS**	**Emphysema**	
Glaucoma	**Hepatitis**	**Gonorrhea**	

   Medication/Treatment/Doctor/Date: _____

   _____

   _____

   Are any of the above active: No_____ Yes_____ If yes, indicate: _____
9. **Any blood relatives with the above illnesses: No_____ Yes_____ (Specify)_____**

   _____
10. **Serious injuries in the past: No_____ Yes_____ (Specify)_____**

    _____
11. **Hospitalizations other than psychiatric (include procedures and/or operations) _____**

    _____

    _____

    _____

Medications Prescribed:_____

_____

12. Any psychiatric hospitalizations/treatment: No_____ Yes_____ Specify where/when: _____

_____

_____

Medications Prescribed:_____

13. Family history of psychiatric illness and/or treatment: No_____ Yes_____ (Specify)_____

_____

14. Recent disorientation or hallucinations: No_____ Yes_____ (Specify)_____

_____

15. Place most often used for medical care/physician: _____

16. Date of last physical examination: _____ Where was it done: _____

Special instructions/current medications: _____

_____

17. Pregnancies/Miscarriages/Abortions: No_____ Yes_____ (Specify)_____

_____

18. Rapid weight loss in past: No_____ Yes_____ (Specify) _____

19. Rapid weight gain in past: No_____ Yes_____ (Specify) _____

20. Insomnia: No_____ Yes_____ (Specify)_____

21. Smoke cigarettes: No_____ Yes_____ Packs per day____ Other_____

22. Date of last chest x-ray: _____

23. Any chest pain: No_____ Yes_____ (Specify)_____

24. Current pain: No_____ Yes_____ (Specify)_____

Medical attention needed: _____

_____

_____

Date: _____ Staff Signature_____

Client willing to see physician if indicated above: No_____ Yes_____
RESPONSIBILITY FOR OBTAINING MEDICAL CARE RESTS WITH CLIENT.

_____

Client/Parent/Guardian Signature