

## Patient Health History

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Who has custody? \_\_\_\_\_

Who can legally make treatment decisions for this patient? \_\_\_\_\_

Allergies to food, medicine, other: \_\_\_\_\_

Current Family Physician and Phone: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Last Physical Exam: \_\_\_\_\_

Any problems experienced during pregnancy with this patient? (Include any alcohol, cigarettes, drug use, complications): \_\_\_\_\_

Any problems experienced during the birth of this patient? \_\_\_\_\_

Does the patient have current or past problems in the following areas? *(please check as indicated)*

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eating
<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Wounds not healing/ easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Street Drugs
<input type="checkbox"/>	<input type="checkbox"/>	Vision/ glasses needed	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Gums/ Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/ Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/ vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Blackouts/ Fainting/ Seizure	<input type="checkbox"/>	<input type="checkbox"/>	Liver/ Yellow Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/ Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/ Bladder
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Walking/ Standing
<input type="checkbox"/>	<input type="checkbox"/>	Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/ Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping too much
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping too little
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Lead/ Chemical Exposure
<input type="checkbox"/>	<input type="checkbox"/>	Anemia/ Low Blood count	<input type="checkbox"/>	<input type="checkbox"/>	Weight: gain _____ Loss _____
<input type="checkbox"/>	<input type="checkbox"/>	Breathing/ Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____ Pounds in _____ time
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Pain now or in recent past
<input type="checkbox"/>	<input type="checkbox"/>	Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Accidents

	YES	NO
Has the patient or a family member had a cough for more than three weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient or a family member coughed up blood in the last six months?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient or a family member had fevers and /or night sweats?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient or a family member been exposed to anyone with tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>

**Female only:**  
 Date of first period: \_\_\_\_\_ Date of last period: \_\_\_\_\_

Has the patient had first pelvic exam? \_\_\_\_\_yes \_\_\_\_\_no

Has the patient ever been hospitalized for any medical reasons such as illness, accidents, surgeries or tests?

\_\_\_\_\_yes \_\_\_\_\_no If yes:

Reason for hospitalization \_\_\_\_\_

Where was the patient hospitalized? \_\_\_\_\_

When was the patient hospitalized? \_\_\_\_\_

What medications is the patient taking now? (psychiatric and medical to include prescription, over the counter and herbals)

\_\_\_\_\_ None or list below

Name of medication?	Dose/Amount	How Often	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has the patient taken any psychiatric meds in the past?

\_\_\_\_\_yes \_\_\_\_\_no If Yes:

Name of medication	Dose/Amount	How Often?	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has the patient had psychiatric care in the past? (such as psychiatrist, psychologist, social worker, nurse, counselor or psychological testing?)

\_\_\_\_\_yes \_\_\_\_\_no If Yes

For What Reason?	When?	Where?	Was he/she hospitalized?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have any of the patient's family members had any of the following?

- | YES                      | NO                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Depression                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Bipolar Disorder                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Suicide                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Schizophrenia                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Manic Depression                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety Disorder                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol/ Drug Problems                   |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Attention Deficit Hyperactivity Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                             |

- | YES                      | NO                       |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis         |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Dementia/ Senility         |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach Problems           |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems             |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell                |
| <input type="checkbox"/> | <input type="checkbox"/> | Nerves                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer: _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures (what kind) _____ |

Please identify family member and disorder here:

---



---

Does the patient need assistance in any of the following areas?

- | YES                      | NO                       |                 | YES                      | NO                       |                               |
|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bathing         | <input type="checkbox"/> | <input type="checkbox"/> | Dressing                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Hygiene         | <input type="checkbox"/> | <input type="checkbox"/> | Ability to walk independently |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeding         | <input type="checkbox"/> | <input type="checkbox"/> | Money Management              |
| <input type="checkbox"/> | <input type="checkbox"/> | Toileting       | <input type="checkbox"/> | <input type="checkbox"/> | Driving                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Tying Shoelaces |                          |                          |                               |

Describe assistance needed? \_\_\_\_\_

---

Describe the patient's play/recreation activities (involved in school plays, sports, etc.) \_\_\_\_\_

---

Describe the patient's talents and skills: \_\_\_\_\_

Describe any family activities that involve the patient \_\_\_\_\_

---

Parenting Practices: \_\_\_\_\_ Spanking \_\_\_\_\_ Time Out \_\_\_\_\_ Remove privileges \_\_\_\_\_ Other

Describe: \_\_\_\_\_

Significant Individuals in the patient's life: \_\_\_\_\_

---

List all individuals who live in the same household as the patient: \_\_\_\_\_

---

Signature of person completing the form: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Clinician's Signature: \_\_\_\_\_ Date/ Time \_\_\_\_\_