Phoenix
COUNSELING SERVICES, LLC

Client Name: _____ DOB: _____

Medical History Form

Here at Phoenix Counseling, LLC we often find that Medical and Emotional Wellness are closely related. The next few pages are about your physical health. All of this information is confidential, and you don't have to answer any questions you are uncomfortable with. If you have questions about the information, please let us know.

General Information

Primary Care Doctor: _____ Phone: _____
Date of last Exam: _____ Results: _____

If it has been more than one year since your last physical health exam, we recommend a follow-up with your primary care doctor.

If you are presently receiving non-routine medical care please explain: _____
_____

IF so, how long have you been under medical care? _____

Height: _____ Weight: _____ BMI (body mass index): _____

Present Medical Concerns: (*check all that apply)*

__ fever
__ bleeding gums
__dizziness
__ convulsions
__ stomach pain
__ blueness of lips/nails
__ night sweating
__ infections or abscesses
__ double vision/ loss of vision
__ severe nose bleeds
__ Nausea or vomiting
__ Coughing/breathing difficulties
__ High blood pressure
__ Pain/difficulty urinating
__ Loss of hearing/buzzing or ringing
__ Migraine or recurrent headaches
__ Blood in urine/ Kidney Stones
__ Spitting up phlegm/mucus/blood
__ Frequent colds or sore throat
__ Numbness or tingling
__ Chronic pain in muscles, bones or extremities

Medical Conditions/ Past History: (*Check all that apply*)

__ Cancer
__ Alzheimer's
__ Cirrhosis
__ Heart attack/heart disease
__ Lupus
__ Lyme Disease
__ Parkinson's Disease
__ Multiple Sclerosis
__ Cystic Fibrosis
__ Cerebral Palsy
__ Muscular Dystrophy
__ Polio
__ Seizure Disorders
__ Urinary tract infections or kidney stones
__ Broken bones
__ Strokes
__ Heart murmur
__ Blood infection
__ Diseases of the arteries
__ Tendency to bleed easily
__ Anemia
__ Ulcers
__ Prostate problems
__ Head injuries
__ Dizziness or fainting
__ Eczema/Psoriasis
__ Mononucleosis
__ Malaria
__Thyroid Problems
__ Pneumonia
__ Allergies/Hay Fever
__ Asthma
__ Abnormal chest X-ray
__ whooping Cough
__ Jaundice
__ Gall Bladder Problems
__ Scarlet Fever/Rheumatic Fever
__ Mumps
__Measles
__ German Measles
__ Chicken Pox

__ Surgery/type? When? _____
__ Hepatitis/ type? When treated? _____
__ TB/ Date of last test:
_____
__ Diabetes/ insulin type & dosage? _____
__ Sexually Transmitted Disease (STD)/ Type & When treated?
_____
__ other: _____

__ I have never had any of the above

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Allergies: *(Circle/Explain)*
Do you have any food allergies? Yes No If yes, please explain: _____

Do you have any allergies/adverse reactions to drugs? Yes No If yes please explain: _____

Women Only: *(Circle/Explain)*
Do you have any menstrual problems? Yes No If yes, please explain: _____

Date of last OBGYN exam: _____

Are you pregnant? Yes NO If yes, are you receiving prenatal care? Yes No

If you have had any of the following please indicate the number:
___ Pregnancies ___ Miscarriages ___ Stillbirths ___ Abortions

Childhood History to be Completed by ALL Clients
Informant: _____ Relationship: _____
Did your mother experience any complications during her pregnancy with you? (i.e. R.H. Neg. toxemia, diabetes, substance abuse)
Yes NO If yes, please specify: _____
Were there any complications during your birth? Yes NO If yes specify: _____
Early development: Did you have any difficulties in the following areas:
Walking: Yes NO If yes explain: _____
Talking: Yes NO If yes explain: _____
Toilet Training: Yes NO If yes explain: _____
Any unusual childhood illness? Yes NO If yes explain: _____
Any child care difficulties? Yes NO If yes explain: _____
Any social/behavioral problems? Yes NO If yes explain: _____

Family Medical History:
Father: Current Age: ____ Current Health: _____ If deceased list the age at death and cause of death: _____
_____
Mother; Current Age___ Current Health_____ If deceased list the age at death and cause of death: _____
_____
Siblings: Number of Brothers: _____ Number of Sisters: _____
List any Health Problems: _____
Spouse Health Problems: _____
Children Health Problems: _____

Family Illnesses: (*Please check if you relatives have any of the following. Please include grandparents, aunts, and uncles, but exclude cousins, relatives by marriage and half relatives)*

__ Heart Attacks/disease	__ Congenital Heart Disease	__ Diabetes
__ Strokes	__ Elevated Cholesterol	__ Cystic Fibrosis
__ High blood pressure	__ Alzheimer's	__ Cancer (specify
__ TB	__ Sickle Cell Trait/Disease	type_____)

__ Other: _____