Associates in Mental Health
Administrative Office: (360) 715-2488

Medical History Form

Client Name: _____ Date: _____

Date of Birth: _____ Form completed by: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse/ Equivalent

Primary Care Physician: _____ Doctor's Office: _____ Phone Number: _____

Please list all doctors or medical specialists the client sees now or has seen in the past year:

1. _____
2. _____
3. _____

Date of client's last physical exam: _____ Examined by: _____

Client's Height: _____ Client's Weight: _____ Is client gaining/losing weight? ☐ Yes ☐ No

If "Yes" for weight change: Date gain/loss began: _____ ☐ Amnt gained: _____ lbs. ☐ Amnt lost: _____ lbs.

List and prior hospitalizations:

1. _____
2. _____
3. _____

How is the client's appetite? ☐ Good ☐ Fair ☐ Poor How is the client's sleep? ☐ Good ☐ Fair ☐ Poor

How is the client's energy level? ☐ Good ☐ Fair ☐ Poor Is this a change from normal? ☐ Yes ☐ No

Rate client's general health: _____

Describe any current medical problems or recent changes in client's physical condition:

List all the medications the client is taking; including non-prescription drugs and health supplements:

Drug Name	Dosage	# Per Day	Drug Name	Dosage	# Per Day

Check any of the following in which the client uses/has used and how much/often:

Substance	Past	Now	How Much/Often	Substance	Past	Now	How Much/Often
Hard Liquor				Barbiturates			
Beer/Wine				Cocaine			
Cannabis				Tobacco			
Amphetamines				Coffee			
Heroin				Soft Drinks			
LSD				Other			

Further comments on alcohol and/or drug use including problem use/abuse: _____

Has the client had any previous mental health counseling? ☐ Yes ☐ No If yes, describe below:

Location/Therapist	Dates	Reason

Further comments on mental health care results and/or reasons for termination:

Check any of the following symptoms and the date of onset the client has had in the past three months:

Condition	Onset	Condition	Onset	Condition	Onset
☐ Vision Problems		☐ Unusual bleeding		☐ Menstrual irregularities	
☐ Weakness in arms or legs		☐ Abnormal growth or lump		☐ Hearing loss	
☐ Constipation		☐ Memory loss		☐ Convulsions/Seizures	
☐ Diarrhea		☐ Chronic pain		☐ Headaches	
☐ Stomach aches		☐ Back pain		☐ Nausea or Vomiting	
☐ Fainting		☐ Dizziness		☐ Head injury	
☐ Shortness of breath		☐ Chest pains or tightness		☐ Loss of consciousness	

Check any of the following conditions the client has had and give dates of onset/diagnosis:

Condition	Onset	Condition	Onset	Condition	Onset
☐ Allergies		☐ Epilepsy		☐ Leukemia	
☐ Anemia		☐ Fibromyalgia		☐ Parkinson's	
☐ Angina		☐ Glaucoma		☐ Polio	
☐ Arthritis		☐ Gonohhrea		☐ Rheumatic fever	
☐ Asthma		☐ Gout		☐ Stomach ulcers	
☐ ADD/ADHD		☐ Head trauma		☐ Stroke	
☐ Autism		☐ Heart disease		☐ Syphilis	
☐ Birth defects		☐ Hepatitis		☐ Thyroid disease	
☐ Bladder problems		☐ High blood pressure		☐ Tuberculosis	
☐ Bowel problems		☐ Huntington's Chorea		☐ HIV/AIDS	
☐ Cancer		☐ Hypoglycemia		☐ Other:	
☐ Cerebral Palsy		☐ Hysterectomy		☐ Other:	
☐ Chronic fatigue		☐ Jaundice		☐ Other:	
☐ Circulation problems		☐ Kidney problems		☐ Other:	
☐ Diabetes		☐ Learning disability		☐ Other:	

Please indicate which/whom if any of the client's blood relatives have had any of the above conditions as well:

Have any of the client's blood relatives had any of the following conditions?

☐ Alcohol/drug abuse	☐ Bipolar disorder	☐ Nervous breakdown	☐ Schizophrenia
☐ Anxiety or panic disorder	☐ Depression	☐ Obsessive Compulsive Disorder	☐ Seizure disorder
☐ ADD/ADHD	☐ Dementia	☐ Psychiatric hospitalization	☐ Suicide

Which relatives?

Additional comments on client's or their family's health history: