

MEDICAL/SOCIAL HISTORY

Name: _____ Birth date: _____

FAMILY HEALTH

Please mark an appropriate box for each family member:

	GOOD	POOR	DECEASED	CAUSE OF DEATH
Father				
Mother				
Sisters				
Brothers				
You				
Grandparents				
Grandparents				

YOUR HEALTH

Please check any illness or problems you have had:

<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Child Hyperactivity
<input type="checkbox"/> Hives or Rashes	<input type="checkbox"/> Hernia	<input type="checkbox"/> German Measles
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Measles
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Mumps	<input type="checkbox"/> Polio	<input type="checkbox"/> Overdose
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Allergies	<input type="checkbox"/> Venereal Warts	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Herpes
<input type="checkbox"/> Other Explain: _____		

Allergies: _____

Explain Above Illnesses: _____

HOSPITALIZATIONS/PRIOR TREATMENT

If you have ever been hospitalized, please give the required information below:

DURATION MO./YEAR	REASON / OPERATION / ILLNESS	HOSPITAL / TREATMENT CENTER	CITY & STATE

Counselor/Therapist: _____ Dates: _____ Phone: _____

Psychiatrist: _____ Dates: _____ Phone: _____

Other: _____ Dates: _____ Phone: _____

HISTORY OF CHEMICAL DEPENDENCY

Do you have any history of **drug** use? () Yes () No If yes, describe below in detail:

Drug(s): _____

Frequency of use: _____

Length of use: _____

Treatment: _____

Last date of use: _____

What made you decide to use? _____

What made you decide to quit? _____

Do you have any history of **alcohol** abuse? () Yes () No If yes, describe below in detail:

Frequency of use: _____

Length of use: _____

Treatment: _____

Last date of use: _____

What made you decide to use? _____

What made you decide to quit? _____

CRIMINAL/LEGAL HISTORY

Do you have any criminal or legal history? () Yes () No --- If yes, explain (include offense, dates, consequences, current status): _____

Have you ever been accused of a crime or abuse? () Yes () No If yes, Explain (include offense, dates, consequences, current status): _____

Probation Officer: _____ Attorney: _____

Caseworker: _____ Phone: _____

TESTS AND IMMUNIZATIONS

Any significant medical problems? () Yes () No

If yes, describe below in some detail. State each health condition or problem separately and explain its effects, duration, treatment, etc.

Check those you have had and enter the year you were last given the test or shots.

TESTS/SHOTS	YEAR:	TESTS/SHOTS	YEAR:
() Chest x-ray		() Tetanus Shots	
() GI Series		() Polio Series	
() Electrocardiogram		() Flu Injections	
() TB Test		() Mumps Shot	

<input type="checkbox"/> Smallpox Shots		<input type="checkbox"/> Measles Shots	
<input type="checkbox"/> Hepatitis B Series		<input type="checkbox"/> Other	
<input type="checkbox"/> Other		<input type="checkbox"/> Other	

MEDICATIONS

List all medications you are presently taking and indicate if you are allergic to a medication.

PRESENTLY TAKING	DOSE

Have medical records been sent? _____

Date of last physical exam? _____ Date of last dental exam? _____

Date of last vision exam? _____ Date of last tetanus shot? _____

Client Signature _____ *Date* _____

Staff Signature _____ *Date* _____