

Confidential Health Assessment Form-ADULT

Client Name: _____ DOB _____ Date: _____

(OR) Name of person completing this form: _____

Relationship to Client

Please describe any serious health problems/injuries or surgeries, past or present.

Please check all of the items that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever (unknown origin) | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches-Chronic | <input type="checkbox"/> Sexual difficulty |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Diarrhea-Chronic | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV illness | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver problem | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Weight Gain or Loss | <input type="checkbox"/> Eye Problem |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Fatigue | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Depression or Anxiety |
| <input type="checkbox"/> Allergies (food, animals, medicines or other substances): _____ | | |
| <input type="checkbox"/> Other: _____ | | |

Please identify the doctor or clinic treating you currently for the above items:

Problem	Physician or Medical Facility
_____	_____
_____	_____
_____	_____

Please list any medical or mental hospitalizations you have had in the last five years:

Dates of Hospitalization	Where Hospitalized	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medications you are currently taking: (If needed, add at bottom of pg. 2)

Medication	Dosage	Frequency	Condition being Treated	Prescribing Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Women Only: Have you had any pregnancies? Yes _____ No _____

If yes, gives dates: _____

Miscarriage(s) Yes _____ No _____ Date(s) _____

Abortion(s) Yes _____ No _____ Date(s) _____

Turn Page Over & Complete Other Side >>

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Please indicate the frequency with which you have used any of the following substances in the last six months:

Key:

5=Daily 4=4-5 times/week 3=1-3 times/week 2=more than once/month 1=less than once/month 0=never

___ Tranquilizers	___ "Huffing"	___ Ecstasy (XTC)
___ Cigarettes or Cigars	___ Oxycontin	___ Heroin or Methadone
___ Alcohol	___ Codeine	___ LSD, PCP or Mushrooms
___ Sleeping Pills	___ Marijuana	___ Amphetamines (Speed/Uppers)
___ Laxatives	___ Cocaine, Crack	___ Caffeine (cups/ounces) _____
___ Other _____		

Have you ever been treated for drug or alcohol problems? ___ Yes ___ No

If yes, when and where? _____

Have you ever attended AA, NA or Al-Anon? ___ Yes ___ No

1. Has anyone ever expressed any concern about your use of drugs or alcohol? ___ Yes ___ No
2. Have people annoyed you by criticizing your drinking or drug use? ___ Yes ___ No
3. Have you felt bad or guilty about your drinking or drug use? ___ Yes ___ No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ___ Yes ___ No

Have you ever had a DUI? ___ Yes ___ No If yes, when and where? _____

Have you ever had an alcohol or drug-related arrest? ___ Yes ___ No If yes, what was the charge? _____

Have you ever been court-ordered to attend an Alcohol Diversion Program? ___ Yes ___ No

If yes, when and where? _____

Would you like to sign a release allowing your therapist and your physician (PCP) to communicate about your concerns and/or medications? ___ Yes, ___ No, or ___ I'd like to discuss this with my therapist.

How did you hear about us? Please check all that apply: Insurance/Managed Care referral
 Internet search Phone Book Physician's Office Friend/Family Our website
 Professional Referral's Name (e.g. therapist, attorney, pastor):

Other: _____

Please note below anything else you think would be helpful for us to know about your health, or any medications you did not have room for on page 1. Thank you!

