COME 2 CHANGE COUNSELING, LLC

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Brief Health Information Form

A. Identification

Client's name: _____ Case #: _____ Date: _____

B. Medical History

1. Starting with your childhood and proceeding up to the present, list ***all*** diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

Have you previously received or are you currently receiving psychiatric and/or psychotherapy treatment? __

2. Describe any allergies you have.

To what	Reaction you have	Allergy medications taken

3. List *all* medications, drugs, or other substances you take or have taken in the last year–prescribed, over-the--counter vitamins, herbs, and others.

Medication/drug	Dose (how much)?	Taken for	Prescribed and monitored by

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

2. Other physicians treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

D. Health habits

1. What kinds of physical exercise do you get?

_____

_____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day? Which?

Cups: _____ Type:_____

Bottles/Cans: _____ Type:_____

3. Do you try to restrict your eating in any way? ❑ No ❑ Yes

How? _____ Why?: _____

_____ _____

4. Do you have any problems getting enough sleep? ❑ No ❑ Yes. If yes, what problems?

_____

_____

E. Other

Do you use tobacco? ❑ No ❑ Yes. Yes. If yes, how many cigarettes/cigars/other do you use each day?

❑ 1–10

❑ 11–21

❑ 21–30

❑ 31+

Have you ever injected drugs? ❑ Yes ❑ No

Ever shared needles? ❑ Yes ❑ No

Have you had HIV testing in the last 6 months? ❑ Yes ❑ No. If yes, results:_____

Are there any other medical or physical problems you are concerned about? _____

_____

_____