Clinical Psychology Services

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Health Information Form

A. Identification

Client's name: _____ Date: ___/___/___

B. Medical caregivers

List at the top your current doctor or primary care provider (PCP) or medical agency. Then list other health care providers, agencies, or clinics treating you in the last 5 years.

Name	Specialty	Address	Phone #	Date of last visit

C. Medical history

1. Starting with your childhood and proceeding to the present, list *all* illnesses, accidents/injuries, surgeries, hospitalizations (including ones for mental illness or substance abuse), periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness, injury, or other condition	Treatment received	Treated by	Results

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Age	Illness, injury, or other condition	Treatment received	Treated by	Results

2. Are you allergic to medications or anything else? ❑ No ❑ Yes. If yes, please describe here.

To what?	Reaction you have	Allergy medications you take

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

Medication, drug, or other substance	Dosage and how often	For what condition?	When started	Effects	Prescribed and supervised by:

4. Have you ever been exposed to toxic chemicals? ❑ No ❑ Yes. If yes, please describe here.

Dates	Kind of work or location	Kinds of chemicals	Effects

D. Health habits

1. How much physical exercise do you get? I (do) _____, for _____ (length of time), ____ days per week.

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2. Do any of the following describe you? ❑ Very conscious of eating healthily ❑ Tend to overeat (binge) ❑ Eat a balanced diet most of the time ❑ Watch my weight very closely ❑ Eat junk foods ❑ Other: _____

3. How was your appetite in the last month? ❑ Normal ❑ Very good ❑ Low

   Do you try to control your eating in any way? ❑ No ❑ Yes. If yes, how (special diets, medications)?

   _____

   Why? _____

4. I have ❑ gained ❑ lost ____ pounds within the last 6 months.

5. What hobbies do you enjoy? _____ How often? _____

6. What problems do you have with sleep? _____

   What do you do to help you sleep? _____

7. Have you ever injected drugs? ❑ Yes ❑ No ❑ Talk about later

   Ever shared needles? ❑ Yes ❑ No ❑ Talk about later

8. Have you had HIV testing in the last 6 months? ❑ No ❑ Yes ❑ Talk about later

E. For women only

1. Menstruation: At what age did you start to menstruate (get your first period)? ____ years old.

   How regular are your periods? _____ How long do they last? _____

   How much pain do you have? _____ How heavy are your periods? _____

   Other experiences during periods? _____

2. Please list all of your pregnancies and attempts to get pregnant:

Your age?	What happened with this pregnancy? Miscarriage, abortion, stillbirth, child born, etc. Other problems?

3. At what age did you first notice signs of menopause? _____

   If you are in or around the age of menopause: What signs or symptoms do you have now (hot flashes, mood swings, menstrual period changes, body pain, etc.)? _____

   _____

   At what age did menstruation stop? _____

F. Other

Are there any other medical or physical problems that you are concerned about, or that you think I should know about? ❑ No ❑ Yes. If yes, describe: _____

_____