COMMUNITY CONCERN – Mental Health Clinic
Physical Health Information

Today's Date:___________

Name:____(Maiden Name) ______________

Height:________________ **Weight:**___________**Age:**_________ **Date Last Physical**______________

Family Doctor name & Address:___________________________D.O.B.__________________________
Pharmacy____

Current Medications: **(Please include prescription, over-the counter and herbal remedies)**

	Medication Name	Amount/dose	For What?	Name of prescribing physician
1				
2				
3				
4				
5				
6				

Are you on a special diet? ❑ Yes ❑No What Diet?______________________________
Allergies: Drugs:__________________ Reaction: ______________________________
Other:__________________ ______________________________

Brief Medical History: Please check "Yes" or "No" if you have or had, any problems with the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart:	☐	☐	Circulation:	☐	☐	Blood Pressure	☐	☐	Stroke:	☐	☐
Cancer:	☐	☐	Digestion:	☐	☐	Ear/hearing:	☐	☐	Muscles:	☐	☐
Diabetes:	☐	☐	Elimination:	☐	☐	Eyes/Vision:	☐	☐	Nose/Throat	☐	☐
Skin:	☐	☐	Headaches:	☐	☐	Breathing:	☐	☐	Energy level:	☐	☐
Seizures:	☐	☐	Persistent Pain	☐	☐	Kidney disease	☐	☐	Sleeping:	☐	☐
Teeth:	☐	☐	Weight Gain/loss	☐	☐	Appetite:	☐	☐	Walking:	☐	☐

Other:____

Surgery: (Dates/type)____

		Yes	No	How much?	How often?
Do you use:	Cigarettes?	☐	☐	____________	________________
	Alcohol?	☐	☐	____________	________________
	Caffeine?	☐	☐	____________	________________
Other drugs?	__________	☐	☐	____________	________________

Please comment here on any problems checked above:___________________________________
____

Past Hospitalizations: **(I have never been hospitalized☐)**
Dates:________________Hospital:__________________Reason____________________________
Dates:________________Hospital:__________________Reason____________________________
Dates:________________Hospital:__________________Reason____________________________

Person to contact in case of emergency: ______________________________________
Relationship:__________________ **Phone:**_________________________

REPORT TO AND FROM PRIMARY CARE PHYSICIAN: (Check here if you do not give permission) ☐
I give my permission to Community Concern to release & receive mental health and substance abuse information regarding my treatment to my Primary Care Physician listed above for the purpose of facilitating coordination of care. I understand that I have the right to revoke this release at any time. This release shall be valid until ninety days after my last day of treatment or until I revoke this release.

_________________________________ _________________________________
Signature Witness Date