COMMUNITY CONCERN – Mental Health Clinic

Physical Health Information

Behavioral Health * Senior Care * Youth
Community Concern
Your life, your health, your care

Today's Date: _____

Name: _____ DOB: _____ Age: ____

Address: _____

e-mail: _____ SS#: _____

Family Doctor or Clinic Name: _____ Date of last physical: _____

Height: ____ft. ____ inches Weight: _____ lbs.

Pharmacy: _____ Pharmacy Address: _____

Emergency Contact _____ _____ _____

Name Relationship Phone Number

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 currently pregnant? ☐ Yes ☐ No ☐ N/A

Are you on a special diet? ☐ Yes ☐ No What Diet? _____

Allergies: Drug: _____ /Reaction: _____

Other: _____ /Reaction: _____

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?	If yes, do you wish to stop?
Do you use:	Cigarettes?	☐	☐	_____	_____	Y ☐ N ☐
	Alcohol?	☐	☐	_____	_____	Y ☐ N ☐
	Caffeine?	☐	☐	_____	_____	Y ☐ N ☐
Other drugs?	_____	☐	☐	_____	_____	Y ☐ N ☐

Please comment on any above problems: _____

_____

Past Hospitalizations: *I have never been hospitalized* ☐

Dates: _____ Hospital: _____ Reason _____

Dates: _____ Hospital: _____ Reason _____

Dates: _____ Hospital: _____ Reason _____

Agency Use

Date Completed _____ Update _____

☐ No Recommendations

☐ Recommend physical evaluation for above symptoms

☐ Other Recommendations _____

_____

_____

Reviewed by: _____ Therapist _____

Physician or Registered Nurse