



Client Name (Last	First	MI):	Age:	Client #
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Has the client had any of the following health problems?				
Problem	Now	Past	Never	What treatment received and date(s)
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (High or Low)				
Cancer				
Cirrhosis/Liver Disease				
Diabetes				
Epilepsy/Seizures				
Eye Disease/Blindness				
Muscle Problems				
Stomach/Bowel Problems				
Glaucoma				
Headaches				
Head Injury/Brain Tumor				
Hearing Problems/Deafness				
Heart Disease				
Hepatitis/Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral Health/Dental				
Bone Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexual Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Disorder				
Depression				
Eating Disorders				
Hyperactivity/ADD				
Schizophrenia				
Sexual Problems				
Sleep Disorder				
Suicide Attempts				
Other:				
Other:				

Please note family history of any of the above conditions and relationship with client:

Client Name (Last) First (M): Age: Client #

Has client had medical hospitalizations in the last three years? No Yes, if YES, complete below:
 Hospital City Date Reason

Name of prescription, over the counter medication, or herbal therapy <input type="checkbox"/> none	Past or Present	Amount / How many per day	Purpose of Medication	Time / Date of last dose	Any problems with this medication

Allergies/Drug Sensitivities: None Food (Specify): _____ Medicine (Specify): _____ Other (Specify): _____

Pregnancy History (If Applicable): Currently Pregnant? No Yes If YES, expected delivery date?: _____
 Last Menstrual Period? (date): _____ Any significant pregnancy history? No Yes If YES, explain: _____

Last Physical Examination: By Whom: _____ When: _____ Phone Number (if known): _____

Has client had any of the following symptoms in the past 60 days? Please check.

<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Coughing	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Penile Discharge	<input type="checkbox"/> Urination Difficulty
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Cramps	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Pulse Irregularly	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Mole/Wart Changes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Vision Changes
<input type="checkbox"/> Breathing Difficulty	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Shakiness	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Falling	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Confusion	<input type="checkbox"/> Gait Unsteadiness	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sweats (night)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Consciousness Loss	<input type="checkbox"/> Hair Change	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling in Arms & Legs	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Tremor	

Immunizations (Child or MR/DD Only) - Has client had or been immunized for the following diseases: (Please check)
 Chicken Pox German Measles Measles Tetanus Hepatitis B Polio Diphtheria
 Mumps Small Pox Other: _____
 Immunizations within the past year:

Height: _____ **Weight:** _____
 Has client's weight changed in the past year? No Yes
 If YES, by how much (+ or -): _____

Nutritional Screening: (please check): No Problem Not eating Takes liquids only Appetite decrease

Nausea Vomiting Trouble chewing or swallowing Special Diet: _____
 Other: _____

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Pain Screening:	Does pain currently interfere with your activities?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how much does it interfere with these activities (Please check):
<input type="checkbox"/> Not at All	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	

Substance Use History/Current Use (Please check appropriate columns):									
Substance	No Use	Past Use	Current Use	How Much	Substance	No Use	Past Use	Current Use	How Much
Alcohol/Beer/Wine					Hallucinogens				
Marijuana					Inhalants				
Hashish					Cocaine/Crack				
Stimulants					Heroin				
Sedatives					Other:				

Caffeine Use?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Form (coffee, tea, pop, etc):	How much a week? (cups, bottles):	
Tobacco Use?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Form (cigarettes, cigars, etc):	How much a week? (packs, etc.):	
Do you have an Advance Directive for medical care?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	Give details.
Do you have an Advance Directive for psychiatric care?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	Give details.

Print Name (Person completing this questionnaire):	Signature:	Date:
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Comments, Recommendations or Referrals by Medical Reviewer:	<input type="checkbox"/> No Referral Needed
Referral Needed, Action Taken (Specify Below):	
<input type="checkbox"/> Primary Care Physician:	
<input type="checkbox"/> Healthcare Agency:	
<input type="checkbox"/> Specialty Care:	
Comments/Client's Response:	

Comments by clinician (non-medical), if any:	
Signature/credential:	Date:

Medical Reviewer Signature/Credential (Nurse, PA, NP, MD, DO):	Date:
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