Options
Counseling and Family Services

MEDICAL INTAKE FORM

Client #

Age: Height: Weight: Which hand do you use to write? Left Right

PCP:

Are your immunizations up-to-date? No Yes

Do you exercise? No Yes If yes, please describe:

Tobacco: No Yes If yes, # of cigarettes/day: # of years: Last use?

Alcohol: No Yes If yes, frequency? Last use?

Marijuana: No Yes If yes, frequency? Last use?

Drug use: No Yes If yes, frequency? Last use?

Are you pregnant? No Yes Is it possible you could be pregnant? No Yes

MEDICAL HISTORY - Please check *current* or *previous* medical conditions.

Anemia	Fibromyalgia	Arthritis	Gout	Stroke/Seizure
Asthma	Heart attack	HIV	Neuropathy	Substance abuse
Blood clots	Emboli	Heart disease	High cholesterol	Psychiatric illness
Thyroid	Alcoholism	Cancer	Rheumatoid arthritis	Ulcers/Wounds
Anxiety	Depression	MRSA infection	RSD/CRPS	Irregular heartbeat
Diabetes	Emphysema	Osteoporosis	High blood pressure	Sleep Apnea
Frequent UTI	Liver Disease	Kidney Disease	Sexual Dysfunction	

Head injury with loss of consciousness? No Yes If yes, when?

Head injury without loss of consciousness? No Yes If yes, when?

Other:

PAST SURGICAL HISTORY - Please list any previous surgical procedures, the date, and location.

Procedure:	Date:	Location

FAMILY HISTORY – Please check medical conditions that are present in your family history.

Cardiac: Heart attack Irregular heartbeat ☐ Sudden death

Musculoskeletal: Arthritis Rheumatoid disease

Neurological/Psychiatric: Seizures Stroke Depression Psychosis

Endocrine/Hematologic: Thyroid Diabetes Bleeding/clots

Anesthesia problems: No Yes Cancer: No Yes

Musculoskeletal: Arthritis Rheumatoid disease

REVIEW OF SYSTEMS – Please check if you have *current symptoms or* medical problems in the following areas.

Constitutional	None Weight loss Weight gain Insomnia Chronic Fatigue Other:
Ears, Nose, Throat	None Loss of Hearing Seasonal Allergies Sinus Pain Ringing in Ears Other:
Heart	None Chest Pain Hypertension Edema Palpitations High Cholesterol Other:
Respiratory	None Asthma Wheezing Frequent Cough Other:
GI	None Heartburn/Indigestion Ulcer Abdominal Pain Stomach Bleed Other:
Skeletal	None Arthritis Muscle Weakness Joint Pain Back Pain Other:
Skin	None Rash Ulcers Scars Other:
Neurological	None Headaches Seizures Numbness Dizziness Other:
Psychiatric	None Depression Mood Swings Anxiety Other:
Endocrine	None Diabetes Hypothyroid Hyperthyroid Hot Flashes Other:
Hematology	None Easy Bruising Bleeding Anemia Other:
Pain	Do you have pain? No Yes If yes, pain location:

Pain Intensity - Please circle the number, or range of numbers, that best describes the intensity of your pain.

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Mild Moderate Severe Worst pain Imaginable

ALLERGIES None Penicillin Sulfa Latex Other _____

MEDICATIONS - Please list the medications you are taking below.

Medication:	Prescriber:	Frequency:	Dose:	Start Date:

Client Signature: _____ Date: _____