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: _____