DUI Services · Mental Health · Addiction Recovery · Evaluations

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Client Name: ____________________________ DOB: ______________________ Intake Date: ____________________

Primary Physician: ____Client Record #: __________

Past and Current History (circle all that apply to you):

Bronchitis	High Blood Pressure	Heart Problems	Asthma
Seizures	Low Blood Pressure	Kidney Trouble	Pulmonary Problems
Emphysema	Shortness of Breath	Hiatal Hernia	Chest Pain
Paralysis	Thyroid Trouble	Lupus	Leg Swelling
Diabetes	Rheumatic Fever	Ulcers	Arrhythmia
Back Pain	Tuberculosis (TB)	Stroke	Heart Murmur
Pneumonia	Bleeding Problems	Polio	Sleep Apnea
Hepatitis	Thrombophlebitis	Current Pregnancy	C-PAP Machine
Psoriasis	Rheumatoid Arthritis	Past Pregnancies: Complications, miscarriages	Other:

Are you currently being treated for anything circled above? Yes_____________ No _______________

Are you in need of treatment (that you are not currently receiving) for anything circled above? Yes_____ No _______

If yes, please provide details:

____

Have you been treated for any medical problem in a hospital in the past 30 days? Yes__________ No _____________

If yes, please provide details (use back of this form if necessary)____

____

Do you have any allergies (food or medicine?) Yes____________ No ______________

If yes, what? ____

Are you currently taking any medications (prescribed or OTC?) Yes_____ No _____

(If yes, please complete medication log (separate attachment)

Do you smoke? YES, NO If yes, amount per day: ______________________________

Do you drink alcohol? YES, NO If yes, amount per day / week: ______________________________

_______________________________________ _________________________________

Client / Legal Guardian / Parent Date

_______________________________________ _________________________________

Therapist Date