CRC

Adult Medical History

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Name of Provider:

NAME:		DATE:	DOB:
HEIGHT:	WEIGHT:		
CIRCLE: Male Female			
RACE: ☐ Caucasian ☐ Middle Eastern ☐ Asian or Pacific Islander	☐ Native American ☐ Hispanic ☐ Other	☐ African American ☐ Bi-racial	

1. Physician: ______________________________

2. Date of last medical office visit: ______________________________

   Reason for visit: ______________________________

3a. Date last complete physical examination: ______________________________

3b. Date of last eye examination or physical examination that included an eye examination: ______________

4. Dentist: ______________________________

5. Date of last dental office visit: ______________________________

6. Do you have allergic reactions to any medications? ☐ Yes ☐ No
   If yes, please list the medication and describe the reaction, e.g., rash, cough, sneezing, stomach or intestinal problems, etc.

NAME OF MEDICATION	REACTION

7b. Do you have other allergies? ☐ Yes ☐ No
   If yes, please list and describe reaction, e.g., rash, cough, sneezing, stomach or intestinal problems, etc.

ALLERGIES	REACTION

8. Are you currently taking medication **including prescription medications, over-the-counter or sample medications, herbal products, vitamins, nutriceuticals, and respiratory therapy-related drugs such as inhalers?**
   ☐ Yes ☐ No If yes, please list:

MEDICATION (prescription and non-prescription – see above)	PRESCRIBING PHYSICIAN or N/A	DATE STARTED	DOSAGE	HOW OFTEN	REASON FOR MEDICATION

9. Have you taken medications for purposes of managing behavior or mood or attention/concentration?
   ☐ Yes ☐ No If yes, please list:

MEDICATION	PRESCRIBING PHYSICIAN	DATE STARTED	DATE STOPPED	DOSAGE	REASON FOR MEDICATION

10. Have there been any recent (past three months) changes in your medications? ☐ Yes ☐ No
If yes, please list: ____
____
____

11. Have you experienced serious illnesses or injuries in your lifetime? ☐ Yes ☐ No If yes, please list:

ILLNESS OR INJURY	AGE AT TIME OF ILLNESS OR INJURY

12. Have you undergone medical operation(s) or hospitalizations in your lifetime?
☐ Yes ☐ No If yes, please list:

TYPE OF MEDICAL OPERATION/HOSPITALIZATION	REASON FOR OPERATION OR HOSPITALIZATION	WHERE	AGE

13. Have you ever been hospitalized for psychiatric/emotional/behavioral reasons, including substance abuse:
☐ Yes ☐ No If yes, where: ______________________
Dates: from ________ to ________ Counselor's name: ______________________

14. Have you experienced any physical or developmental problems in your lifetime? ☐ Yes ☐ No
If yes, please describe: ____
____

16. Describe your health: ☐ Good ☐ Fair ☐ Poor

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Clinician Comments:

17. In the past 12 months have you had any of the following symptoms?

- ☐ Wears glasses
- ☐ Visual problem
- ☐ Hearing problems
- ☐ Speech/language problems
- ☐ Eating problems
- ☐ Sleeping problems
- ☐ High fevers
- ☐ Convulsions/seizures
- ☐ Fainting spells or blackouts
- ☐ Unusual tiredness
- ☐ Breathing problems or asthma
- ☐ Nosebleeds
- ☐ Headaches
- ☐ Stomach problems
- ☐ Sexually transmitted diseases
- ☐ Back pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Vomiting
- ☐ Frequent infections
- ☐ Frequent urination
- ☐ Menstrual pain, irregular or late menstruation
- ☐ Heart problems
- ☐ Other: ______________________

18. Do you experience physical pain? ☐Yes ☐No
If yes, how often does this occur? (circle the best answer)

Rarely	Occasionally	Sometimes	Often	Very Often
1	2	3	4	5

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Clinician comments:

20. List physical exercise, sports, fitness activities in which you participate regularly.
If not applicable, please circle: **None**

____

____

21. Do you have concerns about your eating habits? ☐ Yes ☐ No
If so, what are they? ____

22. Have you experienced a significant weight gain or loss during the past three months? ____________________

____

23. Place a checkmark by any of the following substances you have used in the past.

☐**None**

- ☐Pep pills or uppers
- ☐Tranqulizers
- ☐Marijuana
- ☐Nicotine (cigarettes, tobacco)
- ☐Inhalants (butane, gasoline,etc.)
- ☐Caffeine
- ☐Alcohol
- ☐LSD/Hallucinogens
- ☐Cocaine/Crack
- ☐Other, please specify: ______________________

26. Do you or anyone you know think you ever had a problem with any of the substances checked above?

☐Yes ☐No

If yes, please state which substances, at what point in your life, who believes it is a problem and why, and if you have ever been treated for substance or drug abuse:

____

____

27. Check appropriate column for following things that you may have done or experienced. Have you...

	NO	YES	If yes, how many times & when
Threatened suicide?			
Attempted suicide?			
Starved self?			
* Done binging or purging?			
Overdosed on drugs			
Injured self on purpose?			
Been arrested?			
Been incarcerated?			

* BINGING is the rapid, uncontolled consumption of large amounts of food.
PURGING is getting rid of food eaten during a binge. The most common method of purging is self-induced vomiting, but some turn to laxatives, fasting, severe diets, vigorous exercise and other methods to counteract a binge.

28. If applicable, have you established advance directives for yourself? ☐Yes ☐ No or Not applicable
If yes, please provide a copy.

FAMILY MEDICAL HISTORY

29. Check any of these conditions which apply to a blood relative: (If checked, indicate which relative.)

CONDITION	RELATIVE
☐ Hyperactivity	__________
☐ Learning problems	__________
☐ Mental illness, including depression (List diagnosis if known)	__________
☐ Alcoholism	__________
☐ Drug Abuse	__________
☐ Family member previous mental health or substance abuse treatment	__________
☐ Diabetes	__________
☐ Epilepsy or seizures	__________
☐ Tuberculosis	__________
☐ Heart problems	__________
☐ Asthma or breathing difficulty	__________
☐ Anemia or blood disease	__________
☐ Cancer	__________
☐ Other serious illnesses	__________
☐ Family member disability	__________

30. Have you received mental health services in past? ☐ Yes ☐ No If yes, please list:

APPROXIMATE DATES OF SERVICE	TYPE OF SERVICE (e.g., Outpatient Counseling home visits, Inpatient hospitalization)	AGENCY	REASONS FOR TREATMENT

CLIENT NAME____ DOB___________________________________

*** FOR OFFICE USE ONLY *** NURSING RECOMMENDATIONS	
Physical Examinations	
Dental Health	
Vision Health	
Nutrition *If yes to key questions, refer to a nutritional specialist*	
Advance Directives *If yes to #28, medical to note for inclusion in Diagnostic Assessment and medical to advise Outpatient Program Mgr*	
Other Medical	

____ ______________________

Reviewing Nurse's Signature /Date

** [__] Reviewed nursing recommendations. _______________ (Therapist initials)

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Clinician's pain assessment (if 3+):	Severity:
Frequency:	Doctors' care:
Duration:	Effects on fx: