Consumer Name: ______________________
Identifier: ____________________________

HOPE REVEALED
BEHAVIORAL HEALTH CENTER INC.
"Healing yesterday, giving hope for tomorrow"

Brief Health Information Form

A. Identification

Client's name: ____________________________________ Case #: ________________ Date: ____________________

B. History

1. Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical condition you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medication you take

3. List all medications, drugs, or other substances you take or have taken in the last year-prescribed, over-the-counter vitamins, herbs, and others.

Medication/drug	Dose (how much)	Taken for	Prescribed and supervised by

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone#	Date of last visit

D. Health habits

1. What kinds of physical exercise do you get?

____

____

2.How much coffee, cola, tea, or other sources of caffeine do you consume each day? Which?

____

____

3. Do you restrict your eating in any way?
How?
____
Why?
____

4. Do you have any problems getting enough sleep? ☐No ☐Yes. If yes, what problems?
____

E. For women only
At what age did you start to menstruate (get your period):________
1. Menstrual period experiences:
a. How regular are they?
____
b. How long do they last?
____
c. How much pain do you have?
____
d. How heavy are your periods?
____
e. Other experiences during periods?
____
2. Please list all of your pregnancies: What happened with this pregnancy?
Your age Miscarriage Abortion Child born Problems?
____
____
____
____
3. Menopause:
a. If your menopause has started, at what age did it start? _________
b. What signs or symptoms have you had?
____
____
____
____

F. Other
Do you use tobacco ☐No ☐Yes. If yes, how many cigarettes/cigars/other do you use each day? ___________
Have you ever injected drugs? ☐No ☐Yes Ever shared needles? ☐No ☐Yes
Have you had HIV testing in the last 6 months? ☐No ☐Yes. If yes, results: ____________________________
Are there any other medical or physical problems you are concerned about?
____
____
____

Would you like to receive more information regarding HIV/AIDS/STDS? ☐No ☐Yes