

HEALTH AND MEDICAL HISTORY
Footsteps Counseling

CLIENT NAME: _____ **ID#** _____
DATE: _____

Primary Physician: _____ Telephone #: _____
Address: _____

Other Physician(s): _____ Telephone #: _____
_____ Telephone #: _____
_____ Telephone #: _____

Current or recent medications: **None**
(Include dates taken, dose and frequency, and doctor prescribing the medication)

ALLERGIES:

List any medication that has ever caused allergic, adverse, or unusual reactions for client:

List any non-medication allergies (e.g. food, bee stings):

Describe client's history of taking medication as prescribed (CIRCLE):

Psychotropic: POOR FAIR GOOD EXCELLENT

Other Medication: POOR FAIR GOOD EXCELLENT

HEALTH AND MEDICAL HISTORY
Footsteps Counseling

Past illnesses/Injuries/Infectious Diseases and Medical/Surgical Hospitalizations:

Current medical complaints, illnesses, injuries, physical complaints *(include chronic conditions, infectious diseases, hearing, vision, dental problems, handicaps, and restrictions):*

When was the last time the client consulted a Primary Care Physician or Medical Specialist?

Date: _____ Reason for Visit(s): _____

If Client is pregnant, when is the due date? _____

Family/Medical Health History:

Staff Signature: _____

Print Name: _____