

Information to be Furnished by the Client

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Occupation \_\_\_\_\_

I. FAMILY HISTORY:

	<u>Living</u>	<u>Deceased</u>	
	<u>Age</u>	<u>Health</u>	<u>Age at Death</u>
			<u>Cause of Death</u>
Father	—	—	—
Mother	—	—	—
Brothers (B)	—	—	—
and	—	—	—
Sisters (S)	—	—	—
	—	—	—

If there is a family history of any of the following, please indicate how that person is related to you.

	<u>Relationship</u>		<u>Relationship</u>
Cancer	_____	High Blood Pressure	_____
Diabetes	_____	Heart Disease	_____
Kidney Disease	_____		

II. HEALTH HISTORY:

1. Operations, hospitalizations (type and date) \_\_\_\_\_  
\_\_\_\_\_
2. Other illnesses (nature and date) \_\_\_\_\_  
\_\_\_\_\_
3. Have you consulted a physician within the past five years? If so, when and for what reason? \_\_\_\_\_  
\_\_\_\_\_
4. Have you ever consulted a psychiatrist, psychologist, or counselor? If so, when and for what reason? \_\_\_\_\_  
\_\_\_\_\_

III. PERSONAL HISTORY:

(a) Family:

1. Spouse: Birthdate\_\_\_\_\_ State of Health:\_\_\_\_\_

2. Children: Birthdate(s) and State of Health:

(a)\_\_\_\_\_ (d)\_\_\_\_\_  
(b)\_\_\_\_\_ (e)\_\_\_\_\_  
(c)\_\_\_\_\_ (f)\_\_\_\_\_

(b) Personal health habits:

1. Exercise and recreation (indicate frequency)\_\_\_\_\_

2. Medications\_\_\_\_\_

3. Do you smoke? No\_\_\_\_. Yes\_\_\_\_. Amount \_\_\_\_\_

4. Do you drink alcoholic beverages? No\_\_\_\_. Yes\_\_\_\_. Amount \_\_\_\_\_

IV. Do you have any of the following symptoms regularly or severely enough to cause you concern?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Chest Pain	—	—	Abdominal Pain	—	—
Shortness of Breath	—	—	Nausea or Vomiting	—	—
Ankle Swelling	—	—	Diarrhea or Constipation	—	—
Rapid or Irregular Heartbeat	—	—	Nervousness	—	—
Dizziness	—	—	Headaches	—	—
Fainting spells	—	—	Difficulty Concentrating	—	—
Cough productive of Phlegm	—	—	Allergies	—	—
Cough productive of Blood	—	—	Sexual Concerns	—	—
Frequent Urination	—	—	Other health worries	—	—
Painful Urination	—	—	Mental Illness	—	—

V. WOMEN ONLY

1. Menstrual history\_\_\_\_\_

2. Number of pregnancies\_\_\_\_\_

3. Number of living children\_\_\_\_\_

4. Age at menopause\_\_\_\_\_

VI. ADDITIONAL COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_