CHURCHILL COUNSELING SERVICES, INC.
CLIENT MEDICAL INFORMATION - SELF ASSESSMENT

Case #_____

Name_____ Date of Birth_____ Age_____

Gender ___Male ___Female

Allergies_____

Current Symptoms (inc disabilities, disorders, medical/mental concerns)_____

_____

Current Health Needs_____

_____

Current Medications (effectiveness, side effects, allergic/adverse reactions)_____

_____

Do you **exercise**? _____ Type of activity & frequency_____

Are you following a specific **diet**? _____ Describe_____

Relevant Medical History: Please list any past health problems, accidents, surgeries (include dates)

_____

_____

Medications taken in the past (effectiveness, side effects, allergic/adverse reactions)

_____

_____

Immunization Record _____

Pregnancies/Deliveries_____

Personal Care Physician_____ Phone_____

Address _____

Date of Last Physician Visit_____ [ ] Client referred to PCP by CCS staff

May we share treatment information with your PCP? [ ] Yes [ ] No

Has client or any blood relative ever had:			Who?
Cancer	Yes	No	_____
Tuberculosis	Yes	No	_____
Diabetes	Yes	No	_____
Heart Trouble	Yes	No	_____
High Blood Pressure	Yes	No	_____
Stroke	Yes	No	_____
Epilepsy	Yes	No	_____
Suicide	Yes	No	_____
Mental Disorder	Yes	No	_____

_____ _____ _____ _____

Client/Guardian Signature Date MD/RN signature (indicates self-assessment form has been reviewed) Date

_____

Relationship to Client