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

Case #_____

Name_____ Date of Birth_____ Age_____

Gender ___Male ___Female

Allergies_____

Are you currently in counseling elsewhere? No__ Yes___ If yes, where?_____

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?
Suicide (attempt or death)	Yes	No	_____
Mental Disorder	Yes	No	_____

Do you have Advanced Directive for Mental Health? ____Yes ____No
Information will be given to you upon your request.

Is there a need for assistive technology in the provision of services? ____Yes ____No
If so, what_____

_____ _____ _____ _____
Client/Guardian Signature Date MD/RN signature (if indicated) Date

_____
Relationship to Client