THE ATTACHMENT AND TRAUMA CENTER OF NEBRASKA

CLIENT MEDICAL HISTORY

Client: _____ **Date:** _____

Current Primary Medical Care Givers: (Physician, Psychiatrist, Nurse Practitioner)

Name	Name	Name
Title	Title	Title
Phone	Phone	Phone
Address	Address	Address

How would you rate your overall health? Excellent Good Fair Poor

What, if any, concerns do you have about your health?

_____

When was your last physical exam? _____

Please list any medication/substance/food **allergies**:

_____

Please list any medication sensitivities or intolerance:

_____

Health Risk History

Yes No Do you smoke? If yes, how many cigarettes per day?_____

Yes No Have you smoked in the past? _____

Yes No Do you use alcohol? If yes, how often, how much? _____

Yes No Do you use drugs? If yes, how often, how much? _____

Yes No Have you or your partner(s) ever injected drugs? When? _____

Yes No Have you ever had a problem with alcohol, drugs, other addiction?

Yes No Should you cut down on your drinking or drug use?

Yes No Have you been annoyed when others question your drug or alcohol use?

Yes No Have you ever felt guilty about how much you drink or use drugs?

Yes No Have you ever had a drink/used to get going or to treat a hangover?

Yes No Has anyone ever complained about your drinking/using?

Yes No Have you ever gotten into trouble when drinking/using?

With family members? __ With the law? __ With friends? __ Others? __

Yes No Do you usually get into trouble when you drink/use?

#of DUIs_____ what year_____?_____?_____?_____?_____?

#of MIPs_____ what year_____?_____?_____?_____?_____?

Yes No Have you ever had a sexually transmitted disease?

Yes No Have you ever been tested for HIV?

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Review of System

Please note if you currently have, or have ever had, any of the following?

				Approx. date
Recurrent night sweats, chills, fever	__ never	__ current	__ past	_____
Persistent weight loss without dieting	__ never	__ current	__ past	_____
Weight problem/eating disorder	__ never	__ current	__ past	_____
Hepatitis A, B or C	__ never	__ current	__ past	_____
Cancer	__ never	__ current	__ past	_____
Chronic fatigue	__ never	__ current	__ past	_____
Other_____	__ never	__ current	__ past	_____

Do you now have, or have you ever had, conditions involving the following?

Please circle all that apply and describe your condition(s):

Description

Skin _____

Eyes _____

Teeth (dentures, missing teeth, etc) _____

Lungs (asthma)_____

Urinary (chronic bladder infections, etc)_____

Muscles/Joints (arthritis, fibromyalgia, etc)_____

Neurological (head injury, headaches, seizures, dizziness, etc)_____

_____

Gastrointestinal (diabetes, gastric reflux, irritable bowel syndrome, etc)_____

_____

Reproduction/Sexual (menstrual or menopausal difficulties, breast disease prostate problems, erectile difficulties, difficulty with orgasm, sexual difficulties, etc)_____

_____

Endochronological (diabetes, hypo- or hyperthyroidism, etc)_____

_____

Heart or Blood (high blood pressure, high cholesterol, anemia, etc)_____

Other conditions not listed_____

Past injuries/surgeries_____

_____

Please check the items below which describe medical symptoms you have had in the past 12 months.

___ persistent cough

___ thyroid disease

___ abnormal heartbeat

___ severe/persistent headaches

___ seizures

___ shortness of breath

___ high blood pressure

___ balance problems/falling

___ loss of consciousness

___ numbness or weakness of limbs/body

___ muscle weakness
___ joint/aches/pains
___ kidney infection/disease
___ urinary infection
___ stomach/abdominal pains
___ change in vision/trouble with eyes
___ pain in mouth or trouble swallowing
___ speech problem
___ pain/lump/drainage from breasts
___ muscle pain
___ bruise easily
___ trouble urinating
___ liver disease
___ vomiting
___ changes in hearing/trouble with ears
___ feeling clumsy or dropping things
___ sore/swollen neck/glands
___ voice problems

For Female Clients Only

Is there any chance you may be pregnant now? Yes_____ No_____

What was your age at the time of your first pregnancy?_____

How many abortions have you had?_____

How many miscarriages have you had?_____

How many stillbirths have you had?_____

Are your periods regular? Yes_____ No_____

Signature of Client:

_____

Signature of Therapist:

_____

Referred for physical exam? ___ Yes ___ No

To whom? _____ Client willing to accept referral?___ Yes ___ No

Referred for psychiatric evaluation? ___ Yes ___ No

To whom? _____ Client willing to accept referral? ____Yes____No