

**Confidential Brief Health Information Form**

Name: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Phone: (H): \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

SSN: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_

Month and year of last physical: \_\_\_\_\_

Please check any of the following for which you have received care:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> allergies         | <input type="checkbox"/> headaches          | <input type="checkbox"/> heart disease  | <input type="checkbox"/> asthma           |
| <input type="checkbox"/> irritable bowel   | <input type="checkbox"/> diabetes           | <input type="checkbox"/> sleep problems | <input type="checkbox"/> chronic pain     |
| <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> emotional problems | <input type="checkbox"/> arthritis      | <input type="checkbox"/> hearing problems |
| <input type="checkbox"/> vision problems   | <input type="checkbox"/> stomach problems   | <input type="checkbox"/> cancer         | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> blood pressure    | <input type="checkbox"/> head injury        |   |   |

Please list any hospitalizations (dates and reasons): \_\_\_\_\_

Currently under the care of a physician? If so, for what? \_\_\_\_\_

Please list any prior mental health services received: \_\_\_\_\_

For children who are the primary identified client, list immunizations, all developmental milestones, any medications, and health concerns: \_\_\_\_\_

Please check any area where you think you have a problem:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> anxiety, nervousness | <input type="checkbox"/> dental health | <input type="checkbox"/> work/academic       |
| <input type="checkbox"/> behavioral problems  | <input type="checkbox"/> depression    | <input type="checkbox"/> ADHD                |
| <input type="checkbox"/> parenting            | <input type="checkbox"/> sleep         | <input type="checkbox"/> stress              |
| <input type="checkbox"/> physical health      | <input type="checkbox"/> reproduction  | <input type="checkbox"/> anger               |
| <input type="checkbox"/> guilt                | <input type="checkbox"/> relationships | <input type="checkbox"/> eating/nutrition    |
| <input type="checkbox"/> weight/body image    | <input type="checkbox"/> self-esteem   | <input type="checkbox"/> alcohol/other drugs |
| <input type="checkbox"/> compulsive behavior  |  |  |

Briefly describe your:

Eating habits: \_\_\_\_\_

Sleep/rest: \_\_\_\_\_

Use of alcohol/other drugs: \_\_\_\_\_

Caffeine intake: \_\_\_\_\_

Smoking: \_\_\_\_\_

Physical exercise: \_\_\_\_\_

Hobbies/play: \_\_\_\_\_

Please describe any medical concerns not listed above that you believe relevant:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date