CLIENT NAME: _____ DATE: ____/____/____ CASE #: _____

WESTWOOD BEHAVIORAL HEALTH CENTER, INC.

HEALTH ASSESSMENT

NAME: _____ AGE: ____ D.O.B.: ____/____/____ TODAY'S DATE: ____/____/____

FAMILY DOCTOR &ADDRESS: _____

DATE OF LAST MEDICAL CHECK-UP: ____/____/____

CURRENT GENERAL HEALTH: ☐ POOR ☐ FAIR ☐ GOOD ☐ EXCELLENT: HGHT. ____ WGHT ____

LIST HOSPITALIZATIONS: _____

_____

LIST ALL MEDICATIONS YOU ARE TAKING AND DOSAGE (include prescribed & over the counter medications; state frequency of use, and any instructions for use; and the prescribing physician's name:

_____

_____

_____

LIST ALL ALLERGIES INCLUDING DRUG ALLERGIES:

_____

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY):

☐ 1. AIDS	☐ 14. Chemical Dependency	☐ 28. High Cholesterol	☐ 41. Prostate Problem
☐ 2. Alcoholism	☐ 15. Chicken Pox	☐ 29. HIV Positive	☐ 42. Psychiatric Care
☐ 3. Anemia	☐ 16. Diabetes	☐ 30. Kidney Disease	☐ 43. Rheumatic Fever
☐ 4. Anorexia	☐ 17. Emphysema	☐ 31. Liver Disease	☐ 44. Scarlet Fever
☐ 5. Appendicitis	☐ 18. Epilepsy	☐ 32. Measles	☐ 45. Stroke
☐ 6. Arthritis	☐ 19. Glaucoma	☐ 33. Migraine Headaches	☐ 46. Suicide Attempt
☐ 7. Asthma	☐ 20. Goiter	☐ 34. Miscarriage	☐ 47. Thyroid Problems
☐ 8. Bleeding Disorders	☐ 21. Gonorrhea	☐ 35. Mononucleosis	☐ 48. Tonsillitis
☐ 9. Breast Lump	☐ 22. Gout	☐ 36. Multiple Sclerosis	☐ 49. Tuberculosis
☐ 10. Bronchitis	☐ 23. Heart Disease	☐ 37. Mumps	☐ 50. Typhoid Fever
☐ 11. Bulimia	☐ 24. Hepatitis	☐ 38. Pacemaker	☐ 51. Ulcers
☐ 12. Cancer	☐ 26. Hernia	☐ 39. Pneumonia	☐ 52. Vaginal Infections
☐ 13. Cataracts	☐ 27. Herpes	☐ 40. Polio	☐ 53. Venereal Disease

WHICH OF THE ABOVE HAS AN IMMEDIATE FAMILY MEMBER HAD A HISTORY OF? (PLEASE LIST by #)

_____

CURRENT PROBLEMS OR COMPLAINTS (PLEASE CHECK ALL THAT APPLY):

☐ Back pain/chronic pain	☐ Fainting Spells	☐ Paralysis or weakness
☐ Blood Pressure	☐ Frequent Headaches	☐ Pregnancy (☐Yes ☐No ☐ Maybe) LMP ____#Pregnancies___#Live Births____
☐ Convulsions or Seizures	☐ Hearing Loss	☐ Problems with sleeping
☐ Dizzy Spells	☐ Loss Of Appetite	☐ Ringing in the ears
☐ Eating Problems	☐ Nausea or vomiting	☐ Unusual fatigue/tiredness

HABITS & HEALTH BEHAVIORS (PLEASE CHECK ALL THAT APPLY):

☐ Alcohol : Presently: ☐ Light, ☐ Moderate, ☐ Heavy ☐ Alcohol: Past: ☐ Light, ☐ Moderate, ☐ Heavy: Type _____

☐ Other Drugs: Presently: ☐Light, ☐Moderate, ☐ Heavy ☐ Other Drugs: Past: ☐ Light, ☐ Moderate, ☐ Heavy: Type _____

☐ Smoking (packs per day ____) ☐ Coffee (cups per day ____)

☐ Chronic or Constant Pain ☐Light, ☐Moderate, ☐ Severe ☐Change in Sleep Pattern ☐ Increased, ☐Decreased, ☐ Interrupted

☐ Change in Nutrition or Eating Habits ☐ Increased, ☐ Decreased ☐Change in Exercise Behaviors ☐ Increased ☐ decreased

REFERRED TO FAMILY PHYSICIAN FOR EVALUATION: ☐ **YES** ☐ **NO**

_____ **DATE: ____/____/____**

SIGNATURE OF DR. OR R.N. STAFF REVIEWING FORM