

**Assessment and Family Therapy of Northwest Ohio**

**Client Medical History**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Who referred you to our office: \_\_\_\_\_

Name of person completing questionnaire: \_\_\_\_\_ Relationship: \_\_\_\_\_

Client Lives with: \_\_\_\_\_ Who has custody (If applicable) \_\_\_\_\_

Client's Occupation: \_\_\_\_\_ Highest Grade Completed: \_\_\_\_\_

**Please specify difficulties that prompted your visit:**

Age of onset of Difficulties: \_\_\_\_\_ Did the concerns suddenly appear over time: \_\_\_\_\_

What led up to these difficulties?

**Medications and dosage taken on an ongoing basis:**

**Current legal issues with client (If any):**

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**Has the client ever been hospitalized or had any operations?** (yes) \_\_\_\_\_ (no) \_\_\_\_\_

Please list history and age:

**Does the client have any allergies?** (Yes) \_\_\_\_\_ (NO) \_\_\_\_\_

Please list:

**Are client's problems related to an injury?** (Yes) \_\_\_\_\_ (No) \_\_\_\_\_

Please specify details:

Did the accident occur while on the job? (Yes) \_\_\_\_\_ (No) \_\_\_\_\_

Was there a motor vehicle Accident? (Yes) \_\_\_\_\_ (No) \_\_\_\_\_

Is the client in litigation: (Yes) \_\_\_\_\_ (No) \_\_\_\_\_

**Prior Psychological Services:**

Service	Date/Age	Provider
Psychological Testing		
Psychotherapy or Counseling		
Neuropsychological Testing		
Other: List		

**Please specify any other information that is pertinent to the client's care:**

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Please Check all that applies:

Constitutional Symptoms	Check
Normal activity and Energy	
Sweating	
Change in Appetite	
Weight loss or gain	
Chills	
Fever	

Musculoskeletal	
Joint Pain/Stiffness	
Swelling	
Inflammation	
Restriction of Motion	
Atrophy	
Back Ache	

Ears, Nose and Throat	Check
Ringing in Ears	
Hearing Loss	
Gum Bleeding	
Nose Bleeding	
Hoarseness	
Difficulty swallowing	
Sinus congestion or pain	

Neurological	Check
Weakness	
Dizziness	
Speech Problems	
Touch Sensation Issues	
Gait or Balance	
Fine motor issues	
Memory	
Loss of Consciousness	
Epilepsy	
Head Injury	
Stroke	

Respiratory	Check
Respiratory Infections	
Shortness of Breathe	
Cough	
Wheezing	
Blood in Sputum	
Asthma	
Pnuemonia	

Gastrointestinal	Check
Food Intolerance	
Abdominal Pain	
Vomiting	
Nausea	
Bloating	
Chronic Diarrhea	
Chronic Constipation	
Inflammatory Bowel Disease	
Bariatric or Stomach Surgery	
Ulcers	

Cardiovascular	Check
Chest Pain	
Palpitations	
Fast Heart Rate	
Arrhythmia	
Shortness of Breath	
Heart Attack	
Bypass surgery	
High Blood Pressure	

Psychiatric	Check
Anxiety	
Mood Changes	
Depression	
Problems coping with daily activities	

Eyes	Check
Double Vision	
Vision Changes	
Prescription Glasses	

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<b>Blood Disorders</b>	<b>Check</b>
Anemia	
Easy Bruising	
Easy Bleeder	
Swollen Nodes	
HIV Positive	
AIDS	

<b>Endocrine</b>	<b>Check</b>
Thyroid Trouble	
Heat or Cold Intolerance	
Diabetes	
Excessive Thirst	
Excessive Hunger	
Excessive Urination	

<b>Medical Conditions</b>	<b>Check</b>
Cancer	
Breast Cancer	
Live Problems	
Kidney Problems	
Bladder Problems	

**Other Medical Conditions (Please list):**

**Please indicate Service(s) Requesting:**

Individual Psychotherapy

Psychological Evaluation

Couple Therapy

Neuropsychological Evaluation

Family Therapy

Attention Deficit Evaluation

Bariatric Assessment

Consultation

Disability Evaluation

Other Please List: