MIDDLETOWN COUNSELING SERVICES, INC.

BRIEF HEALTH INFORMATION FORM
FOR MEDICAID AND MEDICARE CLIENTS

Client's Name:_____
Date of Birth:_____ Gender:_____ Age:_____

PLEASE NOTE: After two missed appointments, we reserve the right to contact Medicaid about your missed appointments even though we cannot bill for them.

Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents, and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions, seizures, and any other medical conditions you have had.
Please list your age at the time of the occurrence, what the illness or diagnosis was, by whom you were treated, and the result of the treatment.

_____
_____
_____
_____

Please circle if there is any family history of any of the following: mental retardation, epilepsy, schizophrenia, birth defects, any mental health diagnosis, or any serious health problems.

Circle any of the following that may apply to you:

Headaches
Dizziness
fainting spells
bowel disturbances
Palpitations
stomach trouble
anxiety
fatigue
No appetite
Anger
take sedatives
insomnia
Nightmares
feel panicky
alcoholism
feel tense
Conflict tremors

Depressed
suicidal ideas
Take drugs
unable to relax
sexual problems
allergies
Don't like weekends and vacations
over ambitious
shy with people
can't make friends
inferiority feelings
can't make decisions
can't keep a job
memory problems
home conditions bad
financial problems
lonely
unable to have a good time
excessive sweating
often use aspirin or painkillers

concentration difficulties
high fevers
Pneumonia
Flu
encephalitis
convulsions
head injury
vision problems
hearing problems
weight problems
asthma
allergies
anemia
high/low blood pressure
sinus problems
hyperactivity
accident prone

Any other health issues:_____
_____

Please list any additional problems or difficulties here:

_____
_____

Have you ever injected drugs? _____ Ever shared needles? _____
Any family history of substance abuse? _____ If so, what substance?_____

Is your father alive? ___ If yes, his age?____ If deceased, when:_____ Cause of death?_____

Is your mother alive? ___ If yes, her age?____ If deceased, when:_____ Cause of death?_____

Are there any members of the family about whom information regarding illness, etc. is relevant?_____

_____

Is there any other health information you feel would be helpful for your therapist to know so he or she may more better understand you? ____ If yes:_____
_____