HEALTH HISTORY

Client Name:
Client CATT #:

CURRENT MEDICAL CARE

What Primary Care/Family Doctor(s) are you currently receiving treatment from?

Physician Name	*Name of Practice/Agency*	*Telephone Number*
		( )
		( )

What Special Care Physicians are you currently receiving treatment from?

		( )
		( )
		( )

Current Medication	*Reason for Medication*	*Helpful?*	*Dose*	*Frequency*	*Prescribing Physician*
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			
		☐Yes ☐No			

Past Medication	*Reason for Discontinuation*	*Helpful?*
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No
		☐Yes ☐No

LAST PHYSICAL EXAMINATION

Doctor/Doctor's Office	**Date**	**Phone No. (if known)**

Client Name:
Client CATT #:

HEALTH CONCERNS **Please check all that apply**

Health Concern	Now	Past	Never	Treatment Received and Date(s)
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (high or low)				
Bone/Joint Problems				
Cancer				
Cirrhosis/Liver Disease				
Diabetes				
Epilepsy/Seizures				
Eye Disease/Blindness				
Fibromyalgia/Muscle Pain				
Glaucoma				
Headaches				
Head Injury/Brain Tumor				
Hearing Problems/Deafness				
Heart Disease				
Hepatitis/Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral Health/Dental				
Stomach/Bowel Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexually Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Disorder				
Depression				
Eating Disorder				
Hyperactivity/ADD				
Schizophrenia				
Sexual Problems				
Sleep Disorder				
Suicide Attempts/Thoughts				
Other:				
Other:				

FAMILY HISTORY

Please note in the space below family history of any of the above conditions and client's relationship to that family member.

Client Name:
Client CATT #:

MEDICAL HOSPITALIZATIONS/SURGICAL PROCEDURES IN THE LAST 3 YEARS?

☐ *Yes* ☐ *No* *If yes, complete the information below.*

Hospital	City	Date	Reason

ANY OF THE FOLLOWING IN THE PAST 60 DAYS? **Please check all that apply.**

❑Ankle Swelling	❑Coughing	❑Lightheadedness	❑Penile Discharge	❑Urination Difficulty	❑Other: _____
❑Bed-wetting	❑Cramps	❑Memory Problems	❑Pulse Irregularity	❑Vaginal Discharge	_____
❑Blood in Stool	❑Diarrhea	❑Mole/Wart Changes	❑Seizures	❑Vision Changes	❑ Other: _____
❑Breathing Difficulty	❑Dizziness	❑Muscle Weakness	❑Shakiness	❑Vomiting	_____
❑Chest Pain	❑Falling	❑Nervousness	❑Sleep Problems		
❑Confusion	❑Gait Unsteadiness	❑Nosebleeds	❑Sweats (night)		
❑Consciousness Loss	❑Hair Change	❑Numbness	❑Tingling in Arms & Legs		
❑Constipation	❑Hearing Loss	❑Panic Attacks	❑Tremor		

PREGNANT? PREGNANT IN THE PAST? ☐ **NOT APPLICABLE**

Currently Pregnant?	**Are you currently breast feeding?**	**Receiving pre-natal healthcare?**
☐No ☐Yes	☐No ☐Yes	☐No ☐Yes
If yes, expected delivery date _____		If yes, indicate provider _____
Last Menstrual Period Date	**Any significant pregnancy history? If yes, explain** ☐No ☐Yes	

ALLERGIES/DRUG SENSITIVITIES

☐ **None**

☐ **Food (specify):**

☐ **Medicine (specify):**

☐ **Other (i.e. Seasonal Allergies - specify):**

IMMUNIZATIONS (REQUIRED FOR CHILD OR MR/DD ONLY) ☐ **NOT APPLICABLE**

Has client had or been immunized for the following diseases? Please check.

❑Chicken Pox	❑Diphtheria	❑German Measles	❑Hepatitis B	❑Measles
❑Mumps	❑Polio	❑Small Pox	❑Tetanus	❑Other:

Immunizations Within the Past Year

Client Name:
Client CATT #:

NUTRITIONAL SCREENING (PLEASE CHECK.)					☐ NOT APPLICABLE
☐**Special Diet:** _____ _____ _____	**Eating** ☐More ☐Not Eating ☐Less	**Drinking** ☐More ☐Takes Liquids Only ☐Less	**Appetite** ☐Increased ☐Decreased	☐Nausea ☐Vomiting ☐Trouble Chewing or Swallowing	☐Other: _____ _____ _____

HEIGHT/WEIGHT	
Height	**If reporting for a child, has height changed in the past year?** ☐No ☐Yes If yes, by how much (+ or -)?
Weight	**Has client's weight changed in the past year?** ☐No ☐Yes If yes, by how much (+ or -)?

PAIN SCREENING

Does pain currently interfere with activities? ☐No ☐Yes

If yes, how much does it interfere with these activities (please check)

☐Not at all ☐Mildly ☐Moderately ☐Severely ☐Extremely

What is the source of the pain? _____

STAFF WILL FILL OUT THIS PAGE

Clinician Reviewer Comments (if any)

- ❑ Medical Review Recommended
- ❑ Client was given clinic list
- ❑ Client's Primary Care Physician is: _____

Provider Signature/Credentials	Date

Check Referral(s) Needed and Specify Action(s): ❑No Referral Needed

❑Primary Care Physician:_____

❑Healthcare Agency: _____

❑Specialty Care: _____

❑Other (specify): _____

Recommendations shared with client? If yes, client's response.
❑Yes ❑No

If no, how will recommendations be shared with client?

Medical Reviewer Signature/Credentials (Nurse, PA, NP, MD, DO)	Date