SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

Client's Name _____

Date of Birth _____

Medical History Form: *Please Fill Out Form as Completely as Possible*

* How is the client's physical health? _____

_____

* Does the client have any significant or relevant medical conditions? _____

_____

* Has the client had any serious injuries, surgeries or hospitalization? Yes _____ No _____

Explain: _____

* Does the client have a primary care physician (PCP)? Yes _____ No _____,

If NO, do you need assistance finding a PCP? _____ Would you like SWFGC to talk to the PCP? _____

When was PCP seen last? _____ Reason: _____

* Are all immunizations up to date? Yes _____ No _____

* Has the client ever taken any medications (including psychotropic medications, vitamins, supplements, OTC)?

Yes _____ No _____

Name of Medication	Dosage	How Often is it Taken?	Purpose	Currently Taking

* Does the client have any allergies (food, environmental, medications)? Yes _____ No _____

Explain _____

* Are there any known family health conditions (i.e. asthma, diabetes)?

_____

_____

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Development History (If client is under age 18)

* Was the pregnancy planned? Yes _____ No _____

*Was the pregnancy full term? Yes _____ No _____, If not how many months/weeks? _____

*Any problems during pregnancy (including domestic violence, substance abuse)?

Explain:_____

_____

*Were there any complications during delivery? Yes _____ No _____

Explain: _____

* Were mother/client separated immediately after birth?_____

* Other parent/client separations after birth:

_____

* Describe client as an infant/toddler (i.e. cheerful, fussy, cuddly): _____

Developmental Milestones: PLEASE RATE: 1 FOR ON TIME, 2 FOR EARLY, 3 FOR DELAYED

* Age client 1st sat up _____ Took 1st steps _____

* Spoke 1st word _____ Fed themselves _____

* Toilet trained during day _____ Toilet trained at night _____

* Any history of development concerns? _____

_____

* Any current developmental concerns? _____

_____

Past Psychiatric History

* Has client ever had therapy before? Yes _____ No _____

* List past diagnosis, if known: _____

* Is client currently receiving services from another behavioral health provider? Yes ____ No____

If Yes, Please Provide Contact Information: _____

* Do you plan to discontinue services with current provider? Yes _____ No _____

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Please list past therapy services:

Dates	Provider	Reason why

*Is the client under the care of a psychiatrist? Yes _____ No _____

If Yes, whom? _____

Can SWFGC talk to the psychiatrist: Yes _____ No _____ (if yes, please sign a ROI)

* Has the client ever had a history of suicidal or homicidal tendencies? Yes _____ No _____

If Yes, Please explain:_____

* Has client ever been in hospitalized for behavioral health issues? Yes _____ No _____

If yes, when and where: _____

* If client has received past behavioral health services, did you feel client's treatment was helpful?

Yes _____ No _____ Please Explain:

_____

_____

* Is there a history of mental illness in the family (i.e. Anxiety, Depression, ADHD)? Yes _____ No _____

If so, whom: _____

* I, _____, have filled out this information as accurately as I can for the above named client.

_____ _____

Signature Date

Relation to Client: _____