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 including surgeries, brain injuries, concussions or hospitalizations?
Yes _____ No _____

If Yes, Explain____

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

- If NO, do you need assistance finding a PCP? _______ Does SWFGC have your permission to share information with your PCP? Yes______ No______ initial if No_______

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)?

____

____

SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

Client's Name ________________________________

Date of Birth ________________________________

Development History (If client is under age 18)

* Was the pregnancy with this client 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 current or past history of development concerns?

____

____

____

SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

Client's Name ________________________________

Date of Birth ________________________________

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 _____ NA_____

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 Relation Date