SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

NAME: _____

DOB: _____ **ID #:** _____

Medical History *Please Fill Out As Completely As Possible*

HOW IS THE CLIENT'S PHYSICAL HEALTH? _____

SIGNIFICANT OR RELEVANT MEDICAL CONDITIONS? _____

_____

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, DOES THE CLIENT NEED ASSISTANCE FINDING A PCP? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE PCP'S NAME: _____ **PHONE:** _____

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, OR OVER-THE-COUNTER PRODUCTS? ☐ 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)? _____

_____

_____

Medical History (Page 2)

Please Fill Out As Completely As Possible

ID #: _____

Developmental 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)***?** ☐ YES ☐ NO

EXPLAIN: _____

WERE THERE ANY COMPLICATIONS DURING DELIVERY? ☐ YES ☐ NO

EXPLAIN: _____

WERE MOTHER/CLIENT SEPARATED IMMEDIATELY AFTER BIRTH? ☐ YES ☐ NO

EXPLAIN: _____

OTHER PARENT/CLIENT SEPARATIONS AFTER BIRTH: ☐ YES ☐ NO

EXPLAIN: _____

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? _____

Medical History (Page 3)

Please Fill Out As Completely As Possible

ID #: _____

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, CONTACT INFORMATION: _____

DO YOU PLAN TO DISCONTINUE SERVICES WITH CURRENT PROVIDER? ☐ YES ☐ NO ☐ N/A

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 RELEASE OF INFORMATION)*

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 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 TO CLIENT _____ DATE _____