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:** ____________________

DOES SWFGC HAVE YOUR PERMISSION TO SHARE INFORMATION WITH YOUR PCP? ☐ YES ☐ NO

IF NO, PLEASE SIGN HERE: ____________________

SWFGC requires a signature confirming your decision on a signed Authorization to Disclose and Release Health Information form.

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 ______________