Initial Clinical History and Physical Form

Date: _____

Client Information

Name: _____

Age: _____

DOB: _____

Sex: _____

Primary Physician: _____

Past Medical History: (Please check all conditions that you have or have had.)

Heart Disease ◯	Emphysema ◯
Congested Heart Failure (CHF) ◯	Osteoporosis ◯
High Blood Pressure ◯	Allergy: Food ◯
Stroke/TIA ◯	Allergy: Seasonal ◯
Obstructive Sleep Apnea ◯	TB ◯
Coronary Artery Disease ◯	Hypothyroid ◯
Depression ◯	Hyperthyroid ◯
Anxiety ◯	Hepatitis A B or C ◯
Bleeding Difficulties or Disorders ◯	Diabetes-Diet Controlled ◯
HIV ◯	Diabetes-Oral Medications ◯
Diabetes-On Insulin ◯	
High Cholesterol ◯	
Seizure ◯	
Loss of Consciousness ◯	
Arthritis (Type) ◯	
Asthma ◯	
Cancer: ◯	
Cancer Type/Treatment:	
Other (Specify):	

Past Surgical History

(Type of Surgery & Year)

1._____, 2. _____3. _____4. _____

Prescription Medications

_____

_____

_____

_____

_____

_____

Non-Prescription Medications/Supplements

_____

_____

_____

_____

_

Drug Allergies / Type of Reaction

_____

_____

_____

No Known Drug Allergy ◯

Latex ◯ Tape ◯

Client Name: _____

Social History

Tobacco Use

Never ◯

Quit/When _____

Cigarettes/Pack per Day____

Pipe ◯

Cigars ◯

Chewing Tobacco ◯

Years? _____

Alcohol Use

None ◯

Socially ◯

Daily ◯

Drug Use

None ◯

Past ◯

Marijuana ◯

Amphetamines ◯

Other ◯

Exercise

None ◯

X's Per Week_____

Type: _____

Caffeine Use

None ◯

Occasional ◯

Daily ◯

How Much? _____

Client Name: _____

Family History

Father: Living ◯ Deceased ◯ Age _____ Medical History: High Blood Presser ◯

Diabetes ◯ Cholesterol ◯ Cancer ◯ OR Cause of Death _____

Mother: Living Deceased Age _____ Medical History: High Blood Presser

Diabetes ◯ Cholesterol ◯ Cancer ◯ OR Cause of Death _____

Brothers: Living Deceased Age _____ Medical History: High Blood Presser

Diabetes ◯ Cholesterol ◯ Cancer ◯ OR Cause of Death _____

Sisters: Living ◯ Deceased ◯ Age _____ Medical History: High Blood Presser ◯

Diabetes ◯ Cholesterol ◯ Cancer ◯ OR Cause of Death _____

FOR FEMALES

Are you: Pregnant? ◯ Planning on becoming Pregnant? ◯ Breast Feeding? ◯

Type of Birth Control? _____ LMP? _____

Last Mammogram? _____ Last PAP? _____