Top Level Counseling and Testing Center Confidential Brief Health Information Form

Name: ______________________________ Birth Date: ________/_______/________

Address: ______________________________ Phone: (H) ________________________

______________________________ SSN: ___________________________

Primary Care Physician: ____________________

Today's Date: _____/_____/_____

Month and year of last physical: ________________

Please check any of the following for which you have received care:

____ allergies	____ headaches	____ heart disease	____ asthma
____ irritable bowel	____ diabetes	____ sleep problems	____ chronic pain
____ epilepsy/seizures	____ emotional problems	____ arthritis	____ hearing problems
____ vision problems	____ stomach problems	____ cancer	____ thyroid problems
____ blood pressure	____ head injury		

Please list any hospitalizations (dates and reasons): ________________________________

Currently under the care of a physician? If so, for what? ____________________________

Please list any prior mental health services received: ______________________________

For children who are the primary identified client, list immunizations, all developmental milestones, any medications, and health concerns: ____

____

Please check any area where you think you have a problem:

____ anxiety, nervousness	____ dental health	____ work/academic
____ behavioral problems	____ depression	____ ADHD
____ parenting	____ sleep	____ stress
____ physical health	____ reproduction	____ anger
____ guilt	____ relationships	____ eating/nutrition
____ weight/body image	____ self-esteem	____ alcohol/other drugs
____ compulsive behavior		

Briefly describe your:

Eating habits: ____

Sleep/rest: ____

Use of alcohol/other drugs: ____

Caffeine intake: ____

Smoking: ____

Physical exercise: ____

Hobbies/play: ____

Please describe any medical concerns not listed above that you believe relevant:

____

____

______________________________ ______________________

Signature Date