Creekview Assessment Center
Neuro/Psychological Testing

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Brief Health Information Form

A. Identification

Client's name:_____DOB:_____Date: _____

B. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. Medical caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

D. Health habits

1. What kinds of physical exercise do you get?

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day?

3. Do you try to restrict your eating in any way? How? Why?

4. Do you have any problems getting enough sleep?

E. Chemical use

1. Have you ever felt the need to cut down on your drinking? • No • Yes

2. Have you ever felt annoyed by criticism of your drinking? • No • Yes

3. Have you ever felt guilty about your drinking? • No • Yes

4. Have you ever taken a morning "eye-opener"? • No • Yes

5. How much beer, wine, or hard liquor do you consume each week, on the average?

6. How much tobacco do you smoke or chew each week?

7. Which drugs (not medications prescribed for you) have you used in the last 10 years?

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

F. . Please list any family history of physical health problems, chemical use, and mental or emotional Difficulties:

G. Other
Are there any other medical or physical problems you are concerned about?

H. For women only

1. Have you had any problems related to menstruation your period)? :_____

3. Please list all of your pregnancies:

	What happened with each pregnancy?			
Your age	Miscarriage	Abortion	Child born	Problems?

4. Menopause:
   a. If your menopause has started, at what age did it start?

   b. What signs or symptoms have you had?

Note: If you enter treatment with me for psychological problems, may I tell your medical doctor if needed so that he or she can be fully informed and we can coordinate your treatment? • Yes • No