HISTORY AND PHYSICAL WORKSHEET

Client fills this out before Dr. Appointment

Client Name: _____ Date: _____

DOB: _____ Age: _____

CHIEF COMPLAINT: _____

_____

_____

Place of Birth: _____ Where current living: _____

With Whom: _____

Marital Status:

Single _____ Married _____ Separated _____ Divorced _____

1. Divorced _____ Children _____
2. Divorced _____ Children _____
3. Divorced _____ Children _____
4. Divorced _____ Children _____

Total Children:

Boys: _____ Girls: _____ Stepchildren: _____ Grandchildren: _____

School: HS Diploma: _____ College: _____

Work: Employed: _____

How long: _____ Unemployed: _____

Military: ____ Branch: _____ Combat: _____ Nature of Discharge: _____

_____

Physician: _____

Miscellaneous: _____

_____

Family History (Alcohol/Drug History): _____

_____

Current and Past Medical History:

Hepatitis: _____ TB: _____ PUD: _____ HTN: _____ Diabetes: _____

Asthma: _____ Heart Disease: _____ Lung Problems: _____

Gastrointestinal Problems: _____

Hospitalizations: _____

_____

_____

Surgeries: _____

_____

_____

Injuries: _____

_____

_____

Pregnancy and GYN History: G: ___ AB: ___ LMP: ___ Birth Control: _____

Last pelvic exam: _____ Hysterectomy: _____ GYN Problems: _____

_____

_____

Suicide Attempts/Gestures: _____ Thoughts: _____ Plans: _____

_____

_____

Legal Problems:

How many: DUI'S: _____ Last one: _____ Bal: _____

Pending Issues: _____

_____

Jail/Prison: _____ Why: _____

_____

Parole/Probation/Drug Court: _____

Job Problems:

Lost job: _____ Absenteeism: _____

Declining performance: _____

Family relationship problems: _____

_____

_____

Prior Alcohol/Drug Treatment: Where/When/Completed: _____

_____

_____

Review of Systems: _____

_____

Medications

_____

_____

Allergies: _____

DRUG USE HISTORY: Amount, last use, length of use, route of use, withdrawal problems, seizures:

Ethanol (alcohol): _____

_____

Opiates (including Tramadol): _____

_____

Cannabis: _____

_____

Sedatives/Hypnotics- prescribed or illicit, Benzodiazepines: _____

_____

Hallucinogens: _____

Other/Inhalants/Club Drugs: _____

_____

Nicotine Use

Cigarettes: _____ Amount: _____ Chew: _____ Amount: _____

PHYSICAL EXAM FROM PROVIDER

(MUST BE FILLED OUT BY MEDICAL PROFESSIONAL)

Alert Orientations: _____ Cognition and Memory: _____

Affect: _____ Paranoia/Hallucinations/Delusions: _____

_____

Vital Signs:

Temp: _____ Pulse: _____ B/P: _____ RR: _____HT: _____

WT: _____ Pain: _____

HEENT: _____

Heart: _____

Lungs: _____

Abdomen: _____

Extremities: _____

Skin (abscesses, track marks): _____

_____

Neurological: _____

Assessment/Problems: _____

_____

Plan: _____

_____

TB Test:

Date: _____ Results: _____

Provider's Signature: _____ Date: _____