INTAKE ASSESSMENT – MEDICAL HISTORY

Client/Patient Name: _____ D.O.B.: _____ Date:_____

Review of systems: Have you or anyone in your family (parents, siblings, children, grandparents, aunts, uncles, cousins) been treated for any of the following conditions?

Condition:	You	Family
Heart disease	☐	☐
High blood pressure	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Thyroid	☐	☐
Neurologic (Parkinson's, head injury, stroke, etc.)	☐	☐
Cataracts/ other eye	☐	☐
Nose/ Mouth/ Throat issues	☐	☐
Hearing	☐	☐
Lung/ Respiratory disease	☐	☐
Skin disease	☐	☐
Kidney disease/ Urinary	☐	☐
Gastrointestinal disease	☐	☐
Liver disease	☐	☐
Muscle or Bone disease	☐	☐
Gynecologic issues	☐	☐
Pregnancy (incl. miscarriages, abortions)	☐	N/A
Sexual Problems (incl. STDs)	☐	N/A
Growths/ Cancer	☐	☐
Hospitalizations	☐	☐
Blackouts	☐	☐
Convulsions/ seizures	☐	☐
Tremors	☐	☐
Dizziness/ fainting spells	☐	☐
Headache	☐	☐
Memory issues	☐	☐
Major weight loss/ gain	☐	☐
Surgeries	☐	N/A
Major injuries	☐	☐

Notes: _____