CLIENT'S NAME _____

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## *PHYSICAL HEALTH HISTORY*

ETHNIC/RACIAL IDENTITY _____ IF NOT BORN IN THE US, AT WHAT AGE DID YOU ARRIVE _____

PRIMARY DOCTOR _____ PHONE # _____

DATE OF LAST VISIT _____

May I exchange pertinent treatment information with your doctor? _____

PSYCHIATRIST _____ PHONE # _____

DATE OF LAST VISIT _____

May I exchange pertinent treatment information with your psychiatrist? _____

Health issues I should be aware of _____

Were you adopted? _____ If so, at what age? _____

MEDICATIONS (list dosages, and why you take them, please include over the counter meds)

_____

| PAST MAJOR ACCIDENTS/INJURIES | WHEN | MAJOR ILLNESSES/OPERATIONS | WHEN |
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|---|---|---|
| Do you take any over the counter medications? (for example to help you sleep, stay awake, suppress appetite, combat headaches, etc.) | yes | no |
| Have you ever used laxatives or enemas on a regular basis? | yes | no |
| Do you have frequent bouts of acid indigestion, stomach upset? | yes | no |
| Do you get severe headaches? | yes | no |
| Do you see a chiropractor or acupuncturist? | yes | no |
| Do you have recurring pain anywhere? | yes | no |
| Do you suspect/know you or your partner is infertile? | yes | no |
| *For males only* - # of children you have fathered _____ | | |
| *For females only* - Do you experience mood changes before or during your menstrual period? | yes | no |
| *For females only* - Have you had problems with your menstrual periods? (irregular, severe bleeding) | yes | no |
| *For females only* - Are you going through or finished with menopause? | yes | no |

*For females only* - # of pregnancies _____ # of live births _____ # of miscarriages, still-births, abortions _____
# of children put up for adoption _____

SIGNATURE _____ DATE _____