Health History

Elisme Consulting Services, LLC

HEALTH HISTORY FORM

1. Name : ______________________ Date of birth : ______________

Occupation : ______________________

In Case of Emergency Contact : ______________________

Phone Number Relationship : ______________________

Children and Ages : ______________________

2. Primary Care Physician : ______________________ Phone Number : ______________

3. Serious Medical Illness/Accidents (Identify & give dates) : ______________________

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4. Are you currently on any medications ? ☐ Yes ☐ No

If yes, please list : ______________________

Any past medications ? : ______________________

5. Surgeries or operations (Identify and give dates) :

____

6. Any hospitalizations ? ☐ Yes ☐ No

If yes, when and for what reason : ______________________

7. Have you ever been treated for depression or anxiety ? ☐ Yes ☐ No

If yes, by whom ? ☐ Internist ☐ OB/GYN ☐ Psychiatrist

Please list any medications prescribed ? : ______________________

8. Have you had any previous counselling ? ☐ Yes ☐ No

If yes, when and with whom : ______________________

9. Are you or have you been in the care of a psychiatrist ? ☐ Yes ☐ No

If yes, when and with whom : ______________________

10. Have you ever been treated for alcohol or drug abuse ? ☐ Yes ☐ No

If yes, when and where : ______________________

11. Have you been the victim of physical or sexual abuse ? ☐ Yes ☐ No

12. Do you have suicidal thoughts ? ☐ Yes ☐ No

13. Have you had a suicidal attempt ? ☐ Yes ☐ No If yes, when : ______________

14. Do you or have you had an eating disorder ? ☐ Yes ☐ No

15. Do you have a history of infectious diseases ? ☐ Yes ☐ No If yes, please describe :

16. Do you have any allergies ? ☐ Yes ☐ No

If yes, please describe any adverse reactions : ______________________

17. Is there past or present nicotine use ? ☐ Yes ☐ No

Client's Signature : ______________________ Date : ______________

Legal Guardian Signature : ______________________ Date : ______________