Carroll Counseling Center

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Client Medical History

Client Name_____ Date of Birth_____

Allergies (adverse reactions to medications/foods, etc.)_____

_____

Date of Last Physical Examination_____

Findings from last exam_____

_____

Current Medications	Dosage	Date first prescribed	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations/Surgeries (include dates, complications, adverse reactions to anesthesia, outcomes.)

_____

_____

Medical Conditions (diabetes, hypertension, head traumas, cardiac problems, asthma, cancer, etc.)

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Mental Health and Chemical Dependency History

In-patient hospitalizations (include dates of treatment)

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Family Mental Health or Chemical Dependency History:

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