Key Point
HEALTH SERVICES INC.
OUTPATIENT MENTAL HEALTH PROGRAMS

Client Name: _____ **Client DOB:** _____

ADULT HEALTH HISTORY - MEDICAL

Please explain any selected response(s) on the lines following the selection.

Eyes, Ears, Nose, Throat

- ☐ None Reported
- ☐ Eye/Vision Problems
- ☐ Nose Problems/Nosebleeds
- ☐ Glaucoma
- ☐ Throat Problems
- ☐ Ear/Hearing Problems
- ☐ Other

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Musculoskeletal

- ☐ None Reported
- ☐ Arthritis
- ☐ Gout
- ☐ Bone/Joint Difficulty
- ☐ Other
- ☐ Back Pain/Injuries

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Blood/Lymphatic System

- ☐ None Reported
- ☐ Anemia (Low RBC Count)
- ☐ Other
- ☐ Bleed Easily
- ☐ Bruise Easily

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Circulatory/Cardiac Systems

- ☐ None Reported
- ☐ Coronary Artery Disease
- ☐ Angina
- ☐ Rheumatic Fever
- ☐ Other
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Abnormal EKG
- ☐ Irregular Heart Beat
- ☐ Chest Pain
- ☐ Heart Attack

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Endocrine System

- ☐ None Reported
- ☐ Diabetes
- ☐ Excessive Urination
- ☐ Menopause
- ☐ Other
- ☐ Thyroid Disease
- ☐ Weight Gain
- ☐ Menopause Problems
- ☐ Excessive Thirst
- ☐ Weight Loss
- ☐ Erectile Dysfunction

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Gastrointestinal System

- ☐ None Reported
- ☐ Difficulty Swallowing
- ☐ Diverticulitis
- ☐ Pancreatitis
- ☐ Hepatitis A
- ☐ Hemorrhoids/Rectal Disease
- ☐ Vomiting
- ☐ Diverticulosis
- ☐ Liver
- ☐ Ulcer
- ☐ Hepatitis B
- ☐ Reflux
- ☐ Diarrhea
- ☐ Stomach Pain
- ☐ Jaundice
- ☐ Constipation
- ☐ Hepatitis C
- ☐ Nausea
- ☐ Other

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Genital/Urinary System

- ☐ None Reported
- ☐ Urinary Tract Problems
- ☐ Sexual Difficulties
- ☐ Prostate
- ☐ Sexual Transmitted Disease
- ☐ Infections
- ☐ Other

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Nervous System

- ☐ None Reported
- ☐ Seizures/Epilepsy
- ☐ Loss of Coordination
- ☐ Head Injury
- ☐ Black-Outs
- ☐ Headaches
- ☐ Speech Problems
- ☐ Spinal Cord Injury
- ☐ Dizziness
- ☐ Tremors
- ☐ Loss of Feeling in Hand/Foot
- ☐ Sleep Problems
- ☐ Other

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Respiratory System

- ☐ None Reported
- ☐ Difficulty Breathing
- ☐ Pneumonia
- ☐ Other
- ☐ Frequent Coughing
- ☐ Asthma
- ☐ Tuberculosis/Results
- ☐ Bronchitis

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Integumentary System

- ☐ None Reported
- ☐ Boils
- ☐ Psoriasis
- ☐ Other
- ☐ Itching
- ☐ Rashes
- ☐ Acne
- ☐ Eczema

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_____

Additional Questions

Have you ever had any surgeries? ☐ Yes ☐ No

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_____

Have you had cancer? ☐ Yes ☐ No

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_____

Any abnormal lab tests/results? ☐ Yes ☐ No

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_____

Have you ever had a head injury? ☐ Yes ☐ No

If yes, did you lose consciousness/have a concussion? ☐ Yes ☐ No

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**=For Females Only:*

*Any problems with menstruation? ☐ Yes ☐ No

*Do you plan to become pregnant? ☐ Yes ☐ No

*Do you use birth control? ☐ Yes ☐ No

*Any history of pregnancy, miscarriage or terminations? ☐ Yes ☐ No

ADULT HEALTH HISTORY - FAMILY

If yes, please explain on the lines following selection (family member, health/psychiatric problem)

Has anyone in your family had health problems? ☐ Yes ☐ No

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Has anyone in your family had a psychiatric problem? ☐ Yes ☐ No

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Has anyone in your family had substance-abuse problems? ☐ Yes ☐ No

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ADULT HEALTH HISTORY - PAIN

If yes to either, please explain (on a scale of 1 to 10, 1=lowest, 10=highest, what is your score?)

Are you experiencing any pain right now? ☐ Yes ☐ No

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_____

Do you experience any chronic untreated pain? ☐ Yes ☐ No

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