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Licensed Professional Counselor
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Medical Checklist _____
Client's Name

Age _____ Height _____ Weight _____

Date of last physical exam: _____

Any abnormal findings: (more space on back)
_____
_____
_____

Name of family physician:
_____

Address: _____

Phone #: _____

Person to be called in the event of an emergency:
_____

Address: _____

Phone #: _____

List any prescription and non-prescription medications taken currently or in the last six (6) months:

Regularly Side Effects
_____
_____
_____
_____
_____
_____

Occasionally Side Effects
_____
_____
_____
_____
_____

Comments on effectiveness of above medications:
_____
_____

Check any of the following which you have had:

Yes	No		When	Yes	No		When
___	___	Breathing problems	_____	___	___	Heart problems/irregular beats	_____
___	___	Kidney/Bladder problems	_____	___	___	High blood pressure	_____
___	___	Cancer/tumors	_____	___	___	Menstrual difficulties	_____
___	___	Diabetes	_____	___	___	Thyroid problems	_____
___	___	Headaches	_____	___	___	Glaucoma/vision problems	_____
___	___	Unusual smells or tastes	_____	___	___	Heavy sweats	_____
___	___	Fits/Convulsions	_____	___	___	Increased thirst	_____
___	___	Stomach/Bowel problems	_____	___	___	Sudden episodes of violence	_____
___	___	Dizziness/Black outs	_____	___	___	Other (specify)	_____

Comments: _____

Check any of these habits which you have:

Yes	No		Amount/ Frequency
___	___	Alcohol	_____
___	___	Coffee	_____
___	___	Drugs (specify)	_____

Comments: _____

Note any allergies you have (please specify what (if any) the allergies are to)

Yes	No		
___	___	Drugs	_____
___	___	Foods	_____
___	___	Chemicals	_____
___	___	Other	_____

Have you ever had major surgery? _____ If, yes, please describe:
_____

Have you had major illnesses, such as encephalitis, hepatitis, syphilis, etc? _____ When _____
If yes, please describe (more space on reverse):
_____
_____
_____

Have you had a head injury with a loss of consciousness? _____ When _____

Are you pregnant? _____

Name of person filling out form _____ Date: _____