

Shortness of breath	_____	_____	_____
Heart trouble	_____	_____	_____
High blood pressure	_____	_____	_____
Liver disease	_____	_____	_____
Abdominal diseases - ulcer, hernia, gastritis	_____	_____	_____
Bowel disease, hemorrhoids, pancreatitis	_____	_____	_____
Veneral disease (STD)	_____	_____	_____
Diabetes	_____	_____	_____
Chronic back / neck problems	_____	_____	_____
Memory loss	_____	_____	_____
Hallucinations	_____	_____	_____
Do you grind your teeth?	_____	_____	_____
Do you have mood changes?	_____	_____	_____

Please list all medications (prescription & non-prescription) that you are currently using:

MEDICATION	DOSAGE	FREQUENCY	MD	HOW LONG?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

How do you assess your general health? _____

Client Signature: _____ Date: _____

Clinician Comments:

PLAN:

1. Refer to Medical Director: _____
2. Refer client to own practitioner: _____
3. Clinician will contact client's practitioner: _____
4. Other _____