CLIENT HEALTH INFORMATION

(Client Self Report)

Valeo Behavioral Health Care

Name ______________________ Case No. ______________________

Family History: (Please indicate self, mother, father, sibling)

- ☐ Heart Disease ____________
- ☐ High Blood Pressure ____________
- ☐ Stroke ____________
- ☐ Cancer ____________
- ☐ Glaucoma ____________
- ☐ Diabetes ____________
- ☐ Epilepsy/convulsions ____________
- ☐ Bleeding Disorder ____________
- ☐ Kidney Disease ____________
- ☐ Thyroid Disease ____________
- ☐ Mental Illness ____________

Surgery:

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ☐ Yes ☐ No Planning pregnancy? ☐ Yes ☐ No Birth Control? ☐ Yes ☐ No

Medical History:

- ☐ Headache ____________
- ☐ Shortness of Breath ____________
- ☐ Heart Palpitations ____________
- ☐ Heart Murmer ____________
- ☐ Chest Pain ____________
- ☐ Dizziness/Fainting ____________
- ☐ Poor Circulation ____________
- ☐ Allergies/Hay Fever ____________
- ☐ Asthma ____________
- ☐ Bronchitis ____________
- ☐ Emphysema ____________
- ☐ Pneumonia ____________
- ☐ Ulcer ____________
- ☐ Digestive Disorder ____________
- ☐ ____________
- ☐ Lactose Intolerance ____________
- ☐ Gallbladder Disease ____________
- ☐ Prostate Disease ____________
- ☐ Bowel Irregularity ____________
- ☐ Incontinence ____________
- ☐ Menstrual Problems ____________
- ☐ Veneral Disease ____________
- ☐ Frequent Infections ____________
- ☐ Hepatitis ____________
- ☐ Anemia ____________
- ☐ Arthritis ____________
- ☐ Osteoporosis ____________
- ☐ Liver Disease ____________
- ☐ Bleeding Disorder ____________
- ☐ ____________
- ☐ Cataracts ____________
- ☐ Gout ____________
- ☐ Dentures/Partial Plates ____________
- ☐ Chronic Rashes ____________
- ☐ Problems w/teeth ____________
- ☐ Erectile Dysfunction ____________
- ☐ Prolonged Erection ____________
- ☐ Premature Ejaculation ____________
- ☐ Difficulty w/Orgasm ____________
- ☐ Decreased Sex Drive ____________
- ☐ Glasses/Contacts ____________
- ☐ Poor Hearing/Hearing Aids ____________
- ☐ TB/Exposure to TB ____________
- ☐ ____________
- ☐ ____________

Habits:

- ☐ Smoke: Packs daily ____________
  - How long? ____________
  - Interested in stopping? ____________
- ☐ Smokeless tobacco: ____________
  - Amount used ____________
- ☐ Exercise routine ____________
- ☐ Coffee: Cups daily ____________
  - Other caffeine ____________
  - AlcoholType/amount ____________
- ☐ Street drugs: Type/amount ____________
- ☐ Diet Restrictions ____________
  - Explain ____________
- ☐ Sleep: Difficulty falling asleep ____________
  - Continuity disturbances ____________
  - Snoring ____________
  - Early morning awakening ____________
  - Daytime drowsiness ____________
- ☐ Appetite: Increased ____________
  - Decreased ____________
  - Wt gain/loss ____________

______________________ Client Signature

______________________ Date