Bridges Family Center, LLC

Health Screening

Date: _____

Client Name: _____ Date of Birth: _____

Directions: Please answer the following questions for the individual named above. Have you (client) ever been treated for, or had any known indications of the following? If yes, please explain the nature of the problem dates, and treatment in the space provided.

Primary Care Doctor: _____ Agency: _____

Phone: _____ May we contact your primary Care Doctor? Yes or No

Medication profile: List all prescriptions and all over the counter medications you are currently taking including vitamins and health supplements.

Medication	Dosage Amount	Frequency Taken	How long?	Prescribed by

Y N	Headaches
Y N	High Blood Pressure
Y N	Stomach Problems
Y N	Thyroid
Y N	Sexually active?
Y N	Any Sexually Transmitted diseases
Y N	Currently pregnant or have you have been?
Y N	Do you have any major health problems? If yes, please list them:
Y N	Have you gone more than 3 days without eating food, except when ill?
Y N	Any allergies? If yes, please list them:
Y N	Have you been hospitalized for mental health or thoughts of harm to self or other?
Y N	Have you ever been a victim of physical, emotional, or sexual abuse?
Y N	Are you sleeping well?

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Y N	Do you drink alcohol or use non-prescription drugs/street drugs? If yes, please list them below:			
	Type of Substance	Frequency	How long	Last used

_____ _____

Signature of Client/Parent/Legal Guardian Date

_____ _____

Witness Date