COX BEHAVIORAL HEALTH GROUP LLC

ADULT MEDICAL HISTORY

Name:		
Phone Number of Emergency Contact:		
Phone Number:	Email Address:	
Date of Birth:	Age:	Gender:

SECTION A – CURRENT MEDICAL

Please describe any physical health issues for which you are currently under the care of a physician?	
Physician's Name:	
Address:	Phone:
If there are any other medical personnel involved with you, please list:	
What hospital are you taken to for medical services?	
Please list all prescription and non-prescription medications taken on a regular basis:	
medication:	reason:
medication:	reason:
medication:	reason:

SECTION B – MEDICAL HISTORY
Please check any conditions that apply and describe.

	routine childhood illnesses (i.e. Chicken Pox, Measles)	age/year:
	respiratory problems (i.e. asthma)	age/year:
	cardiovascular problems (i.e. heart conditions)	age/year:
	gastrointestinal (i.e. stomach ulcers)	age/year:
	eating disorders (i.e. anorexia, bulimia)	age/year:
	musculoskeletal (i.e. muscle, bone, joint problems)	age/year:
	neurological (i.e. seizures)	age/year:
	liver or kidney disorders	age/year:
	tuberculosis	age/year:
	hepatitis	age/year:
	cancer	age/year:
	allergies: (please list)	
	sexually transmitted diseases	age/year:
	immune disorders (i.e. HIV/AIDS)	age/year:

SECTION B – MEDICAL HISTORY (continued)		
NOTE: Disclosure of HIV status is optional; such disclosure will be regarded as super-confidential and information will not be re-disclosed without specific written consent of the person served.		
	stress-related medical problems (i.e. chronic headaches, stomachaches)	age/year:
	learning disabilities / intellectual impairments	age/year:
	speech, hearing or vision problems	age/year:
Please describe any delays in developmental history?		
Prior hospitalizations for injuries, illnesses, surgeries, etc.:		
Prior significant head injuries or periods of unconsciousness or coma:		
Please describe any other medical conditions not identified above?		
Please describe any conditions that would prevent you from self-preservation in the case of an emergency:		
SECTION C – FOR WOMEN ONLY		
At what age did you begin regular menstrual cycles? Describe any problems you are having currently you're your menstrual cycle?		
If currently pregnant, how many weeks? . not pregnant _____ weeks pregnant		
Describe any currently problems you are having with a pregnancy or the post-partum phase of pregnancy?		

I certify that the information provided is true and accurate to the best of my knowledge. I understand that the information with be utilized by the Mid-Florida Center, Inc. for the purpose of conducting a comprehensive assessment and evaluation of my need for mental health or substance abuse services. I further certify that, to the best of my knowledge, I am capable of self-preservation in the event of an emergency and if I had impairments that interfere with self-preservation, I would make these known.

_____ _____

client signature date

FOR OFFICE USE ONLY

☐ no medical concerns that warrant referral	☐ medical conditions warrant a referral
☐ the client was recommended to follow-up with medical services and/or a referral was made to:	

_____ _____

staff signature date