Chester Community Clinic
Widener University

Health History Form

Name:______________________________________ Date:______________

What is the reason for your visit today?____

Approx. date when problem began:____________ Briefly describe how it began:______________________

What is your biggest goal for therapy?____

How would you rate your current health? EXCELLENT—VERY GOOD—GOOD—FAIR—POOR

Please rate your ability to complete daily tasks: EXCELLENT—VERY GOOD—GOOD—FAIR—POOR

Smoke/chew tobacco (#/day______________)	**Y / N**	Stroke (date:_______________)	**Y / N**	Pregnant (# weeks:__________)	**Y / N**
Drink alcoholic beverages (#/day:______________)	**Y / N**	Cancer (site:_________________)	**Y / N**	Sexually Transmitted Disease	**Y / N**
Use of illegal substances	**Y / N**	Seizures/Epilepsy	**Y / N**	Rheumatoid Arthritis	**Y / N**
High Blood Pressure	**Y / N**	Bowel/Bladder Dysfunction	**Y / N**	Osteoarthritis	**Y / N**
High Cholesterol	**Y / N**	Acid Reflux or Ulcers	**Y / N**	Osteoporosis/Osteopenia	**Y / N**
Diabetes	**Y / N**	Bleeding Disorder	**Y / N**	Scoliosis	**Y / N**
Heart Attack	**Y / N**	Thyroid Disorder	**Y / N**	Chronic Pain	**Y / N**
Cardiac Bypass	**Y / N**	Hepatitis	**Y / N**	Recent Infection	**Y / N**
Pacemaker	**Y / N**	Kidney Disease	**Y / N**	Headaches/Migraines	**Y / N**
Congestive Heart Failure	**Y / N**	Lyme Disease	**Y / N**	Dizziness or Fainting	**Y / N**
Angina/Chest Pain	**Y / N**	Lupus	**Y / N**	Anxiety	**Y / N**
COPD	**Y / N**	Fibromyalgia	**Y / N**	Depression	**Y / N**
Emphysema	**Y / N**	Multiple Sclerosis	**Y / N**	Other mental health history: ____________________	**Y / N**
Asthma	**Y / N**	Other medical history: ____________________	**Y / N**		

If you answered YES to any of the above, please explain further:__________________________________

____

Prior surgeries/injuries and dates:____

Please list all prescription or over-the-counter medications:____________________________________

Please list any allergies:_________________________

To the best of my ability, I have given and included all pertinent medical information.

Client Signature: ___________________________________ Date:________________

Health History reviewed by student therapist and licensed supervisor and used in determining plan of care.

Student Therapist:__________________________________ Date:________________

Licensed Supervisor:________________________________ Date:________________