CLARKSTON FAMILY
THERAPISTS, LLC
5639 SASHABAW ROAD
CLARKSTON, MI 48346

HEALTH ASSESSMENT

Date:

Patient's Name:				☐ Male ☐ Female			Date Of Birth:				
Occupation:				Height:			Weight:				
Personal Physician/Name:											
Address:											
City/State/Zip:											
Date of last physical examination:											

Please check (✓) appropriate column in order to help us understand your current health problems:

GENERAL SYMPTOMS			MUSCLE-JOINT			GASTRO-INTESTINAL			EYE-EAR-NOSE-THROAT		
Yes	No		Yes	No		Yes	No		Yes	No	
		Headache			Weakness			Poor Appetite			Blurry Vision
		Fever			Twitching			Indigestion			Sore Throat
		Chills			Stiff Neck			Nausea			Stuffy Nose
		Dizzy			Tremors			Vomiting			Hard of Hearing
		Tired			Swelling			Constipation	Other:		
Other:			Other:					Diarrhea			
								Dry Mouth			
						Other:					

CARDIO-RESPIRATORY			FOR WOMEN ONLY			CHILD UNDER 16 Check if immunizations are current		
Yes	No		Yes	No		Yes	No	
		Chest Pain			Excessive Flow			Whooping Cough
		Rapid Heart Beat			Irregular Periods			Diphtheria/Polio/Tetanus
		Shortness of Breath			Cramps			Measles (Rubeola)
		Coughing			Are you pregnant?			German Measles
		Difficulty Breathing	Due Date:					Rubella
Other:			Date of last period:					Mumps

GENITO-URINARY			NEUROLOGICAL			CURRENT HABITS		
Yes	No		Yes	No		Yes	No	
		Frequent Urination			Seizures/convulsions			Smoke tobacco
		Burning Pain			Treatment for seizures	If yes, how much daily:		
		Bed Wetting			Weakness of arms			Alcohol
		Difficulty starting or			or legs	If yes, how much daily:		
		Stopping urination			Paralysis			Coffee
		Sexually Transmitted Disease/s			Numbness	If yes, how much daily:		
		Losing urine when						Exercise regularly
		coughing/laughing				# Hours of sleep nightly		
Other:			Other:			# Meals per day		

DO YOU TAKE ANY MEDICATIONS?	HOW MUCH PER DAY?	STILL USE (Yes or No)

SEXUAL HISTORY			
	Yes	No	
Do you have concerns about sexual orientation or gender identity?			
Have you had unprotected sex with a partner whose health history is unknown to you?			
Are you experiencing any other issues related to sex that the therapist should address in treatment?			
	If yes, please describe:		