Kate Cavett Associates

Brief Health Information Form

Today's Date_____

Name _____ Birth Date_____ Age_____

Address_____ Phone _____

_____weight_____

Primary Care Physian_____Phone_____

Alternative Care Health Practitioner_____ Phone_____

Date of last physical_____ Health Care Visit _____

Are you currently under a physician's care_____ If So what for _____

Prior mental health / chemical dependency services_____

Please check any of the following which you have had:

_____ allergies
_____ arthritis
_____ asthma
_____ blood pressure
_____ irritable bowel
_____ chronic pain
_____ cancer
_____ diabetes
_____ epilepsy/seizures
_____ emotional problems
_____ head injury
_____ headaches
_____ hearing problems
_____ heart disease
_____ sleep problems
_____ stomach problems
_____ thyroid problems
_____ vision problems

Please check any area where you think you/client has a problem:

_____ ADHA
_____ alcohol / other drug
_____ anger
_____ anxiety / nervousness
_____behavioral problems
_____ compulsive behavior
_____ depression
_____ dental health
_____ depression
_____ eating/nutrition
_____ emotional problems
_____ guilt
_____ headaches
_____parenting
_____physical health
_____ reproduction
_____ relationships
_____ self esteem
_____ sleep
_____ stress
_____ weight/ body image
_____ work/academics

Please describe any health issues not listed above that you believe are relevant:

_____

_____

_____

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