

# Kate Cavett Associates

## Brief Health Information Form

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ weight \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ 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:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> allergies         | <input type="checkbox"/> arthritis          | <input type="checkbox"/> asthma          | <input type="checkbox"/> blood pressure   |
| <input type="checkbox"/> irritable bowel   | <input type="checkbox"/> chronic pain       | <input type="checkbox"/> cancer          | <input type="checkbox"/> diabetes         |
| <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> emotional problems | <input type="checkbox"/> head injury     | <input type="checkbox"/> headaches        |
| <input type="checkbox"/> hearing problems  | <input type="checkbox"/> heart disease      | <input type="checkbox"/> sleep problems  | <input type="checkbox"/> stomach problems |
|  | <input type="checkbox"/> thyroid problems   | <input type="checkbox"/> vision problems |   |

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

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> ADHA                | <input type="checkbox"/> alcohol / other drug | <input type="checkbox"/> anger              | <input type="checkbox"/> anxiety / nervousness |
| <input type="checkbox"/> behavioral problems | <input type="checkbox"/> compulsive behavior  | <input type="checkbox"/> depression         | <input type="checkbox"/> dental health         |
| <input type="checkbox"/> depression          | <input type="checkbox"/> eating/nutrition     | <input type="checkbox"/> emotional problems | <input type="checkbox"/> guilt                 |
| <input type="checkbox"/> headaches           | <input type="checkbox"/> parenting            | <input type="checkbox"/> physical health    | <input type="checkbox"/> reproduction          |
| <input type="checkbox"/> relationships       | <input type="checkbox"/> self esteem          | <input type="checkbox"/> sleep              | <input type="checkbox"/> stress                |
|  | <input type="checkbox"/> weight/ body image   | <input type="checkbox"/> work/academics     |  |

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

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