

HEALTH STATUS
 (TO BE COMPLETED BY EACH HOUSEHOLD MEMBER)

NAME: _____ DATE OF BIRTH: _____

MEDICAL HISTORY

Have you had a history of, or treatment for, any of the following:

	NO	YES		NO	YES		NO	YES
Tuberculosis			Depression			Alcoholism		
Cancer			Seizures					
Severe Arthritis			Heart Condition			Chronic Headaches		
Chronic Kidney Condition			Mental/Emotion Problems			Chronic Fatigue		
Colitis			Hemophilia			Other		

Have you ever received treatment for mental problems? Yes No

If yes, when? _____ From whom? _____

Have you taken medication for mental or emotional problems: Yes No

When **Drugs Prescribed**

When	Drugs Prescribed

Have you ever gone to counseling for emotional or family problems? Yes No

If yes, when and who was the counselor? _____

Have you ever had a psychological evaluation or battery of psychological test? Yes No

If so, when? _____

Health Status, cont.

List all prescription medications being taken on a regular basis.

Medication	Reasons for Medication

Do you have any physical disability? Yes No If yes, when and what? _____

Are you receiving disability income? Yes No If yes, list dates began and for what?

Have you ever been treated for drug usage? Yes No If yes, when and where?

Have you ever been treated for alcoholism? Yes No? If yes, when and where?

A statement may be needed from a physician, psychologist, or counselor concerning you and/or your child's past or current physical, mental, or emotional condition. Are you willing to give permission for release of such information if necessary?

No Yes _____

Signature

Date