HORIZONS
MENTAL HEALTH CENTER
A Member of the Hutchinson Regional Healthcare Family

INITIAL MEDICAL VISIT HEALTH HISTORY FORM

CLIENT NAME (please print): _____DOB: _____

Name of person completing form if not client: _____

Relationship to client: _____

REVIEW OF MEDICAL SYMPTOMS

☐ Numbness/	☐ Joint Problems Muscle	☐ Stomach Pain	☐ Rash or Hives
☐ Tingling	☐ Pain	☐ Nausea/Vomiting	☐ Eczema
☐ Headaches	☐ Muscle Weakness	☐ Chest Pain	☐ Psoriasis
☐ Tremors Dizziness	☐ Kidney Infection/	☐ Rapid Heart Rate	☐ Shortness of Breath
☐ Vision Problems	☐ Stones Bladder	☐ High/Low Blood Pressure	☐ Invol. Movements
☐ Hearing Problems	☐ Infection Difficulty	☐ Weight gain or loss	☐ Fever
☐ Insomnia	☐ Urinating Constipation	☐ High/Low Blood Pressure	☐ Other:
☐ Seizures	☐ Diarrhea	☐ Thyroid Problems	

MEDICAL HISTORY

☐ Arthritis	☐ Fibromyalgia	☐ Arrhythmia
☐ Back pain	☐ Coronary artery disease	☐ Cardiac valvular disease
☐ COPD	☐ Hypertension	☐ Renal failure
☐ Asthma	☐ Migraine	☐ Urinary retention
☐ Cancer	☐ Parkinson's	☐ Traumatic brain injury (TBI)
☐ Diabetes	☐ Stroke	☐ Sleep apnea
☐ Hypothyroidism	☐ Chronic pain	☐ Other:
☐ Seizures	☐ Neuropathy	_____
☐ Anemia	☐ Cong. heart failure	

CURRENT MEDICATIONS

Please list all medications – attach a list if there is not enough space provided

Current Medication	Strength/Dose/Schedule	Prescriber/Start Date

Client Name: _____
DOB: _____

VIOLENCE AND TRAUMA

Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside the family; natural disaster; terrorism; neglect; or traumatic grief?

☐ Yes ☐ No ☐ Decline ☐ Don't Know

RECENT LEGAL HISTORY

In the last 30 days how many times has the client been arrested? #Times: _____

☐ Decline ☐ Don't Know