3151 Airway Avenue, Ste. F-206A
Costa Mesa, CA 92626
Phone: (714) 547-8111 Fax: (714) 547-7905

Turning Point
Center for Families

Email: tpcff@sbcglobal.net
Website: www.turningpointsantaana.org

Date: _____

CLIENT MEDICAL HISTORY

Client Name: _____ **Age:** _____ **Date of Birth:** _____

Physician Name: _____ **Phone #:** _____

Date of Last Medical Exam: _____ **Current Prescription Medications & Dosages:** _____

_____

Current Nonprescription Medications: _____

Do you currently use any of the following? *(Check all that apply)*

Alcohol ☐ Caffeine ☐ Marijuana/Hash ☐ Inhalants (Paint/Glue/Gasoline/Cleaning supplies etc.) ☐ Ecstasy ☐ LSD ☐
Pain Killers (Heroin, Methodone, OxyContin, Vicodin, etc.) ☐ Prescription Meds ☐ Crystal Meth ☐ Cocaine ☐
PCP (Angel Dust ☐ Magic Mushrooms ☐ Special K ☐ Nicotine (Cigarettes/Cloves) ☐ Anabolic steroids ☐

Other: _____

Previous Psychotherapy/Counseling? Yes ☐ No ☐ Dates: _____ Reason: _____

Medical History *(Check all that apply and fill-in description)*

Past	Present	Condition	Description
		Heart Trouble	
		Shortness of Breath	
		Pain or pressure in chest	
		High Blood Pressure	
		Stomach problems	
		Dizziness or Fainting	
		Diabetes	
		Unusual Bleeding	
		Frequent or Severe Headaches	
		Epilepsy, convulsions, fits	
		Stroke	
		Head Injury	
		Back Problems	
		Kidney Trouble	
		Bedwetting or soiling	
		Hepatitis, jaundice or liver trouble	
		Pregnancy	
		Other Serious Illnesses	
		Suicidal Thoughts/Attempts	
		Hospitalization(s)	
		Psychological Evaluation (s)	
		Mental Illness Diagnosis(s)	

Client Signature: _____ **Date:** _____

Parent/Guardian's Signature: _____ **Date:** _____

Parent/Guardian's Signature: _____ **Date:** _____