# 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 | | | Asthma | | |
| Severe Arthritis | | | Heart Condition | | | Chronic Headaches | | |
| Chronic Kidney Condition | | | Mental/Emotional Problems | | | Chronic Fatigue | | |
| Colitis | | | Ulcers | | | Insomnia | | |
| Eczema | | | Hemophilia | | | Allergies | | |
| Hayfever | | | Diabetes | | | Other: _____ | | |

Have you ever received treatment for mental health issues? Yes or No

If yes, when? _____ From whom? _____

Have you taken medication for mental or emotional issues? Yes or No

When? Drugs Prescribed

_____

_____

_____

Have you ever participated in counseling for emotional or family problems? Yes or No

If yes, describe: _____

_____

**HEALTH STATUS**

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

If so, when? _____

List all prescription medications being taken on a regular basis.

**Medication** **Reason for Medication**

_____

_____

_____

Date of last visit to doctor and reason:

_____

List all illnesses you have had in the past year.

_____

_____

_____

Do you have any physical disability? _____ If yes, when and what? _____

Have you ever been treated for drug addiction? _____ If yes, when and where? _____

Have you ever been treated for alcoholism? _____ 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**