

MEDICAL HISTORY

CLIENT'S CURRENT MEDICAL STATUS: (Please describe)

Allergies: _____

Injuries: _____

Chronic Conditions: _____

Current Illnesses: _____

Recent Accidents: _____

Hospitalizations: _____

Other: _____

Have you had any rapid weight changes in the past year? Please describe

CURRENT MEDICATIONS AND DOSAGE

Client's past medical history (same as above but in client's past)

SIGNIFICANT FAMILY ILLNESSES (medical and psychiatric)

REVIEWED BY _____ **ON** _____
Signature of M.D. **Date**

RECOMMENDATION OF M.D. _____

ANY REFERRALS TO BE MADE: _____