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

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