ALLEN RECOVERY CENTER
HEALTH SELF ASSESSMENT
(to be completed by client)

Client Name:_____ Social Security No:_____
Address:_____ City, State, Zip Code:_____
Date of Birth:_____ Phone: (Home)_____ (Work)_____
How would you describe your current health? ☐Good ☐Fair ☐Poor
Current doctor(s):_____

Medications: Please list your current medications and their purpose.

Medication	Purpose

Medical History:

1. Select if you had any of the following:
   ☐Heart attack ☐Asthma ☐Sexuallty transmitted disease ☐Cancer
   ☐Diabetes ☐Stroke ☐Recurrent fainting or dizziness ☐High cholesterol
   ☐High blood pressure ☐Chest pain ☐Ulcers ☐Seizures
2. List surgeries/medical hospitalizations:_____
   Diagnosis_____ Year_____ Diagnosis_____ Year_____
   Diagnosis_____ Year_____ Diagnosis_____ Year_____
   Diagnosis_____ Year_____ Diagnosis_____ Year_____
3. Do you smoke? ☐Yes ☐No Packs per day:_____
4. Do you have any other health issues not indicated above that would affect your treatment?

5. List any allergies, including medication, food and environmental:_____
6. Immunizations: Childhood ☐Yes ☐No When:_____
   Tetanus ☐Yes ☐No When:_____
   Pneumonia ☐Yes ☐No When:_____
7. Do you have: Living Will ☐Yes ☐No Durable Power of Attorney for Health Care ☐Yes ☐No
8. Do you have any cultural/spiritual beliefs that would affect your treatment?_____
9. Have you ever had mental health /psychiatric counseling? ☐Yes ☐No Explain:_____
10. Has anyone in your family had mental health concerns? ☐Yes ☐No Explain:_____
11. Check any that you are presently experiencing:
    ☐Headaches ☐Mood swings ☐Sleep disturbance ☐Hopelessness
    ☐Change in appetite ☐Angry outbursts ☐Irritability ☐Crying spells
    ☐Fatigue ☐Difficulty at work ☐Concentration difficulty ☐Thoughts of hurting self
    ☐Racing thoughts ☐Confusion ☐Difficulty at home ☐Thoughts of hurting others
12. Are there any other mental health problems that you feel we should know about? ☐Yes ☐No If so, explain:

_____ _____
Client Signature Date