

Clinical Medical History

Date: _____

Name: _____ Date of birth: _____

Check the box beside the conditions you have been diagnosed with or have had a problem with.

Allergies	Gout	Pneumonia
Anemia	Headache	Polio
Asthma	Heart disease	Prostate disease
Bladder dysfunction	Heart murmur/palpitations	Rheumatic fever
Bleeding disorder	Hepatitis	Rheumatoid arthritis
Bowel Dysfunction	High Blood Pressure	Rubella
Bronchitis	HIV/AIDS	Scarlet fever
Cancer	Incontinence	Seizures
Chest pain	Kidney disease	Sexual/menstrual dysfunction
Depression	Measels/Mumps	Shortness of breath
Diabetes	Mental illness	Stroke
Dizziness/fainting	Muscle weakness	Tetanus
Epilepsy	Nervousness	Thyroid disease
Frequent infections	Osteoarthritis	Ulcers
Gallbladder disease	Osteoporosis	Venereal disease
GI Disorder	Paralysis	Other:
Glaucoma	Peripheral vascular disease	Other:

List all the medications you are presently taking, including over-the-counter medications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies (food/drugs): _____

Do you currently or have you ever

Smoked cigarettes?

Yes No

Yes, _____ packs per day.

Consumed alcohol?

Yes No

Yes, _____ drinks per day.

Consumed Tea/Coffee?

Yes No

Yes, _____ drinks per day.

Please list any hospitalizations or surgeries you have had.

Date	Reason for hospital stay/surgery



Client Information Sheet / Demographics

Date: _____

Name (First/Mid/Last) _____ Age _____

Parent or Legal Guardian (if patient is a minor) _____

Address _____ City _____ Zip _____

Date of Birth ___/___/___ SSN (optional) _____ Gender: M/F

Marital Status: S M D W

Home Phone _____ Cell _____

Email: _____

Emergency Contact Name: _____

Relationship to Client _____ Phone _____

Employer Name/City _____ Phone _____

Do you have health insurance, Medicare, or Medicaid, or have you recently applied for coverage under one of these programs? Yes No

If yes, name of insurance? _____

Primary Care Physician _____ Phone _____

Pharmacy Name/City _____ Phone _____

Consent for Services

My signature below signifies that I understand the following

- Medical services offered through the Good Samaritan Health Clinic may be administered by a variety of licensed medical professionals.
- To ensure healing of the whole person, it may be necessary for the Good Samaritan Health Clinic care providers (physician, nurses, counselors, etc.) to share information about me with other providers involved in my care.
- Results of tests or procedures may be reported to me by telephone.
- Non-medical services may be provided by a variety of non-licensed, professional counselors or other clinicians, which may include students or interns.
- An initial Intake evaluation will be completed on each client.

Understanding the above, I hereby give my consent to receive services from

Date: _____ Client Signature _____

If a minor, Parent/Legal Guardian Signature _____

Date: _____ Witness Signature _____



Permission Form

I give permission to Good Samaritan Health Clinic to share my medical information:

Yes No

If “yes,” information will be shared with the persons I have listed below and to leave messages concerning my health on my listed phone number.

1 _____

2 _____

3 _____

4 _____

5 _____

I give permission to Good Samaritan Health Clinic to leave a message on my provided phone number message machine:

Yes No

Patient Signature: _____

Witness signature: _____

Date: _____