



Jennifer L. Harkins, LPC, PLLC

Medical History

Name: _____ Date: _____ DOB: _____

Physician: _____ Approximate date of last physical: _____

Have you ever had any major operations? Please explain: _____

Have you ever had a serious accident involving head injuries? _____

Has a physician ever informed you or do you have any of the following medical problems:

Heart disease	yes	no	Yellow jaundice or hepatitis	yes	no
High blood pressure	yes	no	Any venereal disease	yes	no
Respiratory disease	yes	no	Any stomach or intestinal disorders	yes	no
Diabetes	yes	no	Any liver disease	yes	no
Arthritis	yes	no	Tumors or growths	yes	no

Additional info: _____

Please list all the medications that you are currently taking including dosage if possible:

_____	_____
_____	_____
_____	_____
_____	_____