Please provide the following information:

GENERAL HEALTH HISTORY FOR THE LAST SIX MONTHS

Rate your current state of physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Condition	When/Comments
☐ Anemia	______
☐ Arthritis	______
☐ Asthma	______
☐ Allergies (food, medications)	______
☐ Breathing or lung problems	______
☐ Cancer / tumors	______
☐ Childhood illness	______
☐ Chronic Pain	______
☐ Convulsions / seizures	______
☐ Developmental disability	
o Type: ☐ Physical ☐ Intellectual	______
☐ Diabetes	______
☐ Heart problems	______
☐ High blood pressure	______
☐ Kidney / bladder infections	______
☐ Liver problems	______
☐ Nutritional problems	______
☐ Sleeping problems	______
☐ Other	______

Date of last physical examination: ______

Any abnormal or unusual findings: ☐ No ☐ Yes ______

Do you experience chronic pain? ☐ Yes ☐ No (if yes, describe):

What is your current pain level? (0 to 10, where zero is none, and 10 is the worst possible.)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you ever been hospitalized for any major illnesses or surgery?

Date	Place	Reason	Duration

Is there a history of mental concerns in your biological family members (parents, children, sibs, grandparents, aunts/uncles, cousins)?