Rehabilitative Health Services
PHONE: (208) 523-5319 FAX: (208) 523-5627
ADDRESS: 1675 Curlew Dr. Ammon, ID 83406

Comprehensive History

Today's Date:

Reason(s) for seeking services/treatment:

Social History

Birthplace: **Upbringing:**
Where grew up, significant info

Developmental History:

Was your biological mother exposed to toxins during pregnancy, or use any substances *(alcohol, tobacco, illegal drugs)* during pregnancy: ☐ YES ☐ NO ☐ Unknown Please describe

Were you born prematurely, or were there any complications during your mother's pregnancy or your delivery? :
☐ YES ☐ NO ☐ Unknown Please describe

Where you in the NICU (neonatal intensive care unit) after you were born? ☐ YES ☐ NO ☐ Unknown How Long?

Did you walk, talk, and potty-train on time (within pediatric recommended milestones), any developmental complications? :
☐ YES ☐ NO ☐ Unknown Please describe

Have you ever received Occupational Therapy or Speech Language Therapy? :
☐ YES ☐ NO ☐ Unknown Please describe

Family (immediate or other significant family relationships): ☐ Prefer not to answer

Name	Relationship	Age	Gender	Lives with client / patient
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Living Situation: ☐ Self ☐ Spouse ☐ Partner ☐ Children ☐ Roommates ☐ Parents ☐ Parent
☐ Rent ☐ Own ☐ Homeless ☐ Supportive Living ☐ Assisted Living ☐ Skilled nursing facility
☐Safe & Sober housing ☐ Other _____

Marital History: ☐ Single ☐ Engaged ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Length of Marriage ☐ Not applicable**:** **# of Marriages** ☐ Not applicable**:**

Occupation ☐ Not applicable **:** | **Length of time at position** ☐ NA**:**

Work History: ☐ No work history last 5 years

Place of Work	Duration

Household Income: ☐ Less than $18K ☐ $18k-$25k ☐ $25k-$50k ☐ $50k-$75k ☐ $75k-$100k ☐ Greater than $100k
☐ SSI ☐ SSDI ☐ Food Stamps ☐ WIC ☐ Cash Assistance ☐ Child Support ☐ Other _____ ☐ Prefer not to answer

Military Service: ☐ No history of military service

Branch	Date of Service (mm/dd/yyyy)	Type of Discharge

Academic History:

Highest level of schooling achieved including GED, trade schools or certifications:

Current Student: ☐ Yes ☐ No

Type of School	Grade or Description of progress	Concerns/Performance

Have you been/are you on a 504 or IEP? ☐ Yes ☐ No If yes… ☐ IEP OR ☐ 504 Why? Please describe

If under 18, any school behavioral intervention plans? ☐ Not applicable ☐ Yes ☐ No If yes, Please describe

Religious or Spiritual Practice: ☐ No religious or spiritual practices ☐ Prefer not to answer Please describe

Hobbies and Interests: Please describe ☐ Prefer not to answer

Medical History

All Prescribed Medications: ☐ No medications, None reported

Name of Medication	Dosage	Directions	Prescribing Provider	Indication (What is the medication for)

Name of Pharmacy where medications were last filled:

Over the Counter medications, vitamins, and supplements: ☐ YES ☐ NO If yes, please describe

What	Used for	Amount	How often

Drug or Other Allergies: ☐ YES ☐ NO known drug or food If yes, please describe

Name of Allergen	Reaction

Current Primary Care Provider:

Medical History: Do you or immediate family (siblings, parents, grandparents) experience any of these medical issues?

Check all that apply

Heart disease	☐ Self	☐ Family	**Hemorrhoids**	☐ Self	☐ Family
Allergies	☐ Self	☐ Family	**Hepatitis**	☐ Self	☐ Family
Anemia	☐ Self	☐ Family	**Hernia**	☐ Self	☐ Family
Arthritis	☐ Self	☐ Family	**Hypertension (High blood pressure)**	☐ Self	☐ Family
Asthma	☐ Self	☐ Family	**Hypotension (low blood pressure)**	☐ Self	☐ Family
Autoimmune Disease _____	☐ Self	☐ Family	**Inflammatory Bowel Disease**	☐ Self	☐ Family
Back problems (including disk or spine)	☐ Self	☐ Family	**Iron Deficiency**	☐ Self	☐ Family
Cancer: Type(s) _____	☐ Self	☐ Family	**Kidney Disease**	☐ Self	☐ Family
Cataracts	☐ Self	☐ Family	**Kidney Stones**	☐ Self	☐ Family
Chickenpox	☐ Self	☐ Family	**Liver disease**	☐ Self	☐ Family
Chronic Bronchitis	☐ Self	☐ Family	**Migraine Headaches**	☐ Self	☐ Family
COPD (Emphysema)	☐ Self	☐ Family	**Multiple sclerosis**	☐ Self	☐ Family
Diabetes	☐ Self	☐ Family	**Obesity/Overweight**	☐ Self	☐ Family
Diverticulitis	☐ Self	☐ Family	**Parkinson's Disease**	☐ Self	☐ Family
Fainting Spells/Passing Out	☐ Self	☐ Family	**Polyps**	☐ Self	☐ Family
Gall Bladder Disease	☐ Self	☐ Family	**Seizures**	☐ Self	☐ Family
Gastritis or Ulcer	☐ Self	☐ Family	**Sexually Transmitted Disease (STID)**	☐ Self	☐ Family
Glaucoma	☐ Self	☐ Family	**Sleep Apnea**	☐ Self	☐ Family
Gout	☐ Self	☐ Family	**Stroke/TIA**	☐ Self	☐ Family
Hearing Loss	☐ Self	☐ Family	**Testosterone (low)**	☐ Self	☐ Family
Heart defect from birth	☐ Self	☐ Family	**Thyroid problems (hypothyroid/hyperthyroid)**	☐ Self	☐ Family
Heart disease	☐ Self	☐ Family	**Tuberculosis or exposure to tuberculosis**	☐ Self	☐ Family
Heart Valve Problems	☐ Self	☐ Family	**Other _____**	☐ Self	☐ Family

Please add additional information if any checked above. Please explain any family history and who if marked above : ☐ No additional information, None reported

Surgeries: ☐ No surgical history, None Reported

Surgery	Reason	Month/Year	Surgery	Reason	Month/Year

Date of last…

Wellness Exam: ☐ Unknown		**Dental Exam:** ☐ Unknown		**Eye Exam:** ☐ Unknown	
Where		Where		Where	

Do you wear glasses or contacts?: ☐ NA ☐ Glasses ☐ Contacts

Any Physical Disabilities (mobility, hearing, site) : ☐ YES ☐ NO Please Describe

Use of any medical devices (wheelchair, cane, walker, CPAP, Insulin Pump, etc): ☐ YES ☐ NO Please Describe

Developmental or Intellectual Disability Service History: ☐ No history, None reported ☐ Currently Receiving

Service Provider	What services

Reproductive History: ☐ Not applicable

Age of first menstrual cycle: ☐

Any significant pre or menstrual concerns: ☐ None ☐ Cramps ☐ Bloating ☐ Appetite changes ☐ Sleep Disturbance ☐ Mood Disturbance

Current Birth Control: ☐ Not applicable

☐ No method ☐ Hormonal (implant, injection, "the pill", patch, vaginal contraceptive ring) ☐ Permanent (hysterectomy tubal)

☐ IUD ☐ Barrier (diaphragm, male/female condom, spermicide) ☐ Other _____

☐ Fertility Awareness-based (e.g. Cycle monitoring)

Have you ever…

been pregnant? ☐ YES ☐ NO **# of times:** ☐ **given birth?** ☐ YES ☐ NO **# of times:** ☐

had a miscarriage? ☐ YES ☐ NO **# of times:** ☐ **had an abortion?** ☐ YES ☐ NO **# of times:** ☐

Psychiatric History

Diagnosis	Date of Diagnosis	Date of Treatment	Method of Treatment	Notes

Psychological Testing History: ☐ No history, None reported

When: **Provider:**

Past Psychiatric Medication Trials *(psychiatric medication you tried in the past)*: ☐ No history, None reported

Medication	Dosage	Purpose	Effectiveness	Side Effects	Notes

Past Psychotherapy *(counseling, therapy)*: ☐ No history, None Reported

Date Range of Services	Agency/Provider	Reason for Seeking Services	Outcome of Therapy

Past Psychiatric Hospitalization: ☐ No history, None Reported

Date	Where	Reason

Accessed a Behavioral Health Crisis Center?: ☐ No history, None reported ☐ 1x ☐ More than 1x Reason(s)

Past Substance Use Treatment Program / Recovery Coaching: ☐ No history, None Reported

Date range of services	Where	Reason

Family Psychiatric History: ☐ Unknown ☐ No history, None Reported

Family Member	Psychiatric Diagnosis

Suicide History: ☐ No past thoughts, plans, or attempts ☐ Past plans or thoughts ☐ Past attempts ☐ Family history

Self-Harm (cutting, burning etc.) History: ☐ YES ☐ NO

Substance Use or Addiction History: ☐ No history, None reported

Substance	Current or Past Use	How Much	How often	How long being used
Caffeine	☐ Current ☐ Past			
Tobacco	☐ Current ☐ Past			
Alcohol	☐ Current ☐ Past			
Marijuana	☐ Current ☐ Past			
Opiates	☐ Current ☐ Past			
Amphetamines	☐ Current ☐ Past			
Cocaine	☐ Current ☐ Past			
Other_____	☐ Current ☐ Past			

Description of any legal issues: Please describe ☐ Not applicable

Arrests:

Convictions:

Pending Legal Issues:

Probation/Parole:

CPS Cases:

Any restraining orders in place?: ☐ Yes ☐ No Please describe ☐ Not applicable

Trauma History:

PAST ☐ Denies Past ☐ Reports Past ☐ Physical abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Neglect ☐ Other _____

Contact with past abuser(s) ☐ Yes ☐ No **Contact with current abuser(s)** ☐ Yes ☐ No