Mommy Groove Therapy & Parent Coaching

Helping families from belly to baby, toddler to 'tween.

Olivia Bergeron, LCSW
MommyGroove.com
917.747.7017
olivia@mommygroove.com

Brief Health Information Form

1. Client's name: ____
First Name Middle Name Last Name

2. Date of Birth: ___/___/___ 3. Today's Date: ___/___/___

4. History:
A) Please list all major diseases, important accidents and injuries, hospitalizations and medical conditions you have had.

Age	Illness	Treatment Received	Treated By	Result

B) Describe any allergies you have.

To what?	Reaction	Allergy Medications

C) List all medications, drugs, or other substances you have taken in the past year: prescribed, over-the-counter, vitamins, supplements, herbs, and others.

Medication/Drug:	Dose Taken:	Prescribed and supervised by:

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D) Please list all of your pregnancies, if applicable.

Your Age	What Happened	Problems?

E) Do you have a history of experiencing PMS?

F) Have you ever had thyroid problems?

G) Have you ever seen a therapist before? If so, when was the last time? Briefly describe why you went and what the outcome was.

5. Medical Caregivers:

A. Please list your current personal physicians, psychiatrists, OB/GYN, etc.

Name	Specialty	Address	Phone #	Date of last visit

6. Health Habits:

A. What kinds of physical exercise do you get?

B. How much coffee, tea, soda and other sources of caffeine do you consume each day?

C. How much alcohol do you consume in an average week?

D. Do you try to restrict your eating in any way? How? Why?

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E. How much sleep are you getting a night? Do you take naps during the day?

F. Do you have difficulty falling asleep or staying asleep?

G. Do you use tobacco?

H. Are there any other medical or physical problems that concern you and that we should talk about?

Signature of the Client:

____

Date of signature: ___________________________