Crossroads Counseling Center, Inc.

CLIENT MEDICAL INFORMATION

Client Name:		Date of Birth:	

EMERGENCY CONTACT INFORMATION

Name:		Relationship to client:	
Street Address:			
City:		State:	Zip Code:
Daytime Phone No.:		Evening Phone No.:	

PRIMARY CARE PHYSICIAN CONTACT INFORMATION

Primary Care Physician and/or Practice Name:			
Street Address:			
City:		State:	Zip Code:
Phone No.:		Fax No.:	

MEDICAL INSURANCE INFORMATION

Primary Insurance Company:			
ID#		Phone No.:	
Secondary Insurance Company:			
ID#		Phone No.:	

CURRENT MEDICATIONS (prescribed and over-the-counter)*

Enter NONE if not currently taking any medications

Prescribing medication is not a function of CCC services to our clients. Information on this form has been provided by the client and/or authorized representative. It is possible that the client may have changed the medications listed below, and/or that the client may take additional medications that are not known to CCC staff. Therefore, CCC does not purport to know or record on this form the complete medication profile for the client.

Medication for Mental Health Needs

Medication Name	Dosage and Frequency	Reason for Medication	Prescribing Physician

Medication for Medical Needs

Medication Name	Dosage and Frequency	Reason for Medication	Prescribing Physician

Current/past medical history - Please answer the following questions and provide details for any Yes answers.			
	Yes	**No**	**Comments/Details**
Any allergies to foods?			
Any allergies to medications?			
Any environmental allergies (insects, weeds, dust, etc.)?			
Any recent physical complaints and medical conditions?			
Any chronic conditions?			
Any communicable diseases (ex. Hepatitis, TB, MRSA)?			
Any disabilities or restrictions on physical activities?			
Any past serious illnesses, serious injuries or hospitalizations?			
Any history of substance use or abuse?			
Any significant communication problems?			
Any advance directives?			

Has the client received a physical exam within the last year? ☐ Yes ☐ No

If a physical exam has been completed within the last year, Crossroads Counseling Center, Inc. requests that you have your/your child's primary care physician or pediatrician provide us with a copy of a recent physical exam and/or health history or provide us authorization to request a copy directly from your physician.

If you do not currently have a physician and need help finding one, Crossroads Counseling Center, Inc. will be glad to assist you in locating a provider in your area.

I understand if medications or medical needs change for myself/my child, that I will need to notify my Specialist as soon as possible. I understand the importance of medication compliance and the need to contact my/my child's physician regarding any side effects or changes in symptoms.

_____

Client or Authorized Representative's Name Signature Date

For CCC Use Only

Does this client have a pre-existing medical condition(s) that could require emergency treatment? ☐ Yes ☐ No
If Yes, identify those conditions and a Plan of Action for emergency situations:
Medical Conditions and/or signs to watch for: _____

Medical Emergency Plan of Action*: _____

_____

* *A note must be included in the individual's ISP indicating the need for this Emergency Medical Plan-of-Action*