

**WARREN STREET FAMILY COUNSELNG ASSOCIATES, INC.
HEALTH SCREENING FORM**

NAME: _____

DATE OF BIRTH: _____ AGE: _____

PRIMARY CARE PROVIDER: _____

Address: _____

Phone Number: _____

Last Physical: _____

ALLERGIES TO MEDICNES: _____

Medicines you are taking now (including birth control pills). Please indicate the amount of medicine you take and how often.

Do you have any major medical illnesses (such as heart disease, diabetes, arthritis, asthma, kidney disease, liver problems, history of cancer or any other medical problem that requires you to see a doctor often or regularly)?

Do you have any eating problems? _____

What medicines do you purchase when you go to the store (pain relievers, digestive aids, vitamins, etc.)?

Do you have any current health concerns? _____

