The Center for Child and Family Advocacy, Inc.
Client Emergency Information Form and Health Assessment

Today's Date: _____

Location of Services: BRYAN DEFIANCE NAPOLEON WAUSEON Home-Based

Client Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Person to notify in the event of an emergency: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Relationship: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Physician's Name: _____ Office Phone: _____

City: _____ State: _____ Zip Code: _____

Date of last physical exam or last doctor's appointment: _____
(Physical recommended if it has been more than two (2) years since you have last seen your physician)

If client is a child, are immunizations up-to-date? Yes _____ No _____

Allergies:

Hospitalizations or surgeries with dates and reasons:

Health problems and current treatment:

Current medications and reasons for taking them:

Please mark an X if any of the following health problems have occurred with you or a family member.

Disease /Problem	Self	Family	Family Member/Explanation
Alcohol/Substance Abuse	_____	_____	_____
Asthma/Respiratory Problems	_____	_____	_____
Bleeding Disorders	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Emotional Problems	_____	_____	_____
Epilepsy/Seizure	_____	_____	_____
Headaches/Neurological Deficits	____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Sickle Cell Disease	_____	_____	_____
Stroke	_____	_____	_____
Suicide	_____	_____	_____
Tuberculosis	_____	_____	_____
Other	_____	_____	_____

There are other healthcare options available, such as Integrated Healthcare, which accepts all types of insurance and offers a sliding fee. Would you like more information? _____ YES _____ NO

Client's/Parent's/Guardian's Signature: _____ Date: _____

Staff Member's Signature: _____ Date: _____

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I refuse to provide my health history: _____ Date: _____

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Physical Recommended: Yes _____ No _____ Reasons: _____

_____

Nurse's/Physician's Signature: _____ Date: _____

FOLLOW-UP WITH CLIENT

Client's acceptance of recommendation: Yes _____ No _____

Comments: _____

Signature: _____ Date: _____

Clinician reviewing recommendation: _____ Date: _____

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1/2015 1/2013
5/2014 3/2011
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