ANTHONY T. MACHI, M.D., L.F.A.P.A.
3509 Hulen St., Ste. 207
Fort Worth, Texas 76107

Health Assessment

NAME: _____ Date of Birth _____

A: Health History:

Please list any hospitalizations (Dates and Reasons): _____

Please check any of the following medical disorders for which you have received care:

- ☐ Allergies
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Epilepsy or Seizure Disorder
- ☐ Headaches
- ☐ Thyroid Disorder
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Menstrual Problems
- ☐ Skin Problems
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Constipation

Do you have any allergies?: NO [ ] YES [ ] To What? _____

_____

Are you currently under the care of a Doctor?: NO [ ] YES [ ] If yes, please list reason for

treatment:_____

_____

Name of Physician_____ City_____

Please list month and year of last physical exam_____

Please list any medications you are presently taking and indicate dosage and time:

_____

_____

_____

_____

******TURN OVER TO COMPLETE******

Please list all prior mental health services received:

With Whom Year How Long

_____

_____

_____

B: Current Psychiatric Status:

Please check any area where you think you may have a problem:

- ☐ Anxiety, Nervousness, Panic
- ☐ Anger, Irritability
- ☐ Depression, Sadness, Suicidal Thinking
- ☐ Trauma, Injury
- ☐ Sexuality
- ☐ Hallucinations
- ☐ Delusions
- ☐ Obsessions, Compulsions, Ruminations
- ☐ Hyperactivity
- ☐ Attention Difficulties
- ☐ Alcohol Abuse
- ☐ Other Drug Abuse
- ☐ School or work
- ☐ Family Relationships
- ☐ Friendships

Other:_____

C: Health Behaviors:

Briefly Describe your:

1.Eating Habits:._____

2. Sleep /Rest Patterns:_____

3. Physical Exercise: _____

4. Alcohol: _____

5. Caffeine: _____

6. Smoking: _____

7. Other drugs: _____

8. Family History of Psychiatric, Psychological, Alcohol, Drug Problems:

_____

_____

_____

_____

Patient/Parent Signature Date