

# 2. Personal History

|                                    |    |
|------------------------------------|----|
| A. Documents to Assemble Checklist | 11 |
| B. Personal Health Information     | 12 |
| C. Medical History                 | 14 |
| D. Family Information              | 15 |
| E. Education & Work History        | 16 |
| Notes Page                         |    |



## 2-A. Documents to Assemble Checklist

**IMPORTANT!!** The following documents should be assembled in order to apply for services and benefits. Make copies of all of these documents and file them for easy access. Make sure to retain your original documents in a safe place. When you call to make an appointment, ask which documents you need to bring with you.

- \_\_\_\_\_ The “Personal Health Information” section beginning on next page
- \_\_\_\_\_ Social Security Card
- \_\_\_\_\_ Birth certificate
- \_\_\_\_\_ Marriage certificate
- \_\_\_\_\_ Military discharge papers (DD214)
- \_\_\_\_\_ Birth certificates for children
- \_\_\_\_\_ Bank statements from last 6 months
- \_\_\_\_\_ Insurance policies (type and numbers)
- \_\_\_\_\_ Proof of income (paycheck stub, Social Security statement, 1040 Tax Return)
- \_\_\_\_\_ Medical bills, receipts for utilities, rent
- \_\_\_\_\_ Documentation of all communication regarding insurance (letters, phone calls, etc., include the name of the person you spoke with and date of communication)

## 2-B. Personal Health Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (primary): \_\_\_\_\_ Phone (secondary): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Medical Insurance (i.e. HMO): \_\_\_\_\_

Medical Identification Number: \_\_\_\_\_

Allergies: \_\_\_\_\_

### Medications

| <u>Medication</u> | <u>Dosage</u> | <u>Reason</u> |
|-------------------|---------------|---------------|
| _____             | _____         | _____         |
| _____             | _____         | _____         |
| _____             | _____         | _____         |
| _____             | _____         | _____         |
| _____             | _____         | _____         |
| _____             | _____         | _____         |
| _____             | _____         | _____         |

### Conditions Needing Medical Alert (i.e. diabetes, epilepsy, hypertension, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Emergency Contact(s)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (primary): \_\_\_\_\_ Phone (secondary): \_\_\_\_\_

*Emergency Contact(s) (cont.)*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (primary): \_\_\_\_\_ Phone (secondary): \_\_\_\_\_

**Primary Care Physician (PCP)**

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**Other Doctor(s)**

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

## 2-C. Medical History

Please provide indicated information for all providers, including physicians, psychologists, neuropsychologists, dieticians, etc.

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

| Date(s) of Treatment: | Services Provided | Treatment Facility |
|-----------------------|-------------------|--------------------|
| _____                 | _____             | _____              |
| _____                 | _____             | _____              |
| _____                 | _____             | _____              |

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

| Date(s) of Treatment: | Services Provided | Treatment Facility |
|-----------------------|-------------------|--------------------|
| _____                 | _____             | _____              |
| _____                 | _____             | _____              |
| _____                 | _____             | _____              |

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

| Date(s) of Treatment: | Services Provided | Treatment Facility |
|-----------------------|-------------------|--------------------|
| _____                 | _____             | _____              |
| _____                 | _____             | _____              |
| _____                 | _____             | _____              |

## 2-D. Family Information

### Spouse/Significant Other

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (primary): \_\_\_\_\_ Phone (secondary): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### Children

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### Parents

Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (primary): \_\_\_\_\_ Phone (secondary): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (primary): \_\_\_\_\_ Phone (secondary): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## 2-E. Education & Work History

### Education

|                   | School Name | Year Complete |
|-------------------|-------------|---------------|
| Grade School      | _____       | _____         |
| High School       | _____       | _____         |
| GED               | _____       | _____         |
| Vocational School | _____       | _____         |
| Associate Degree  | _____       | _____         |
| Bachelor's Degree | _____       | _____         |
| Graduate Degree   | _____       | _____         |

### Work History

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Dates Worked: \_\_\_\_\_

Type of Work: \_\_\_\_\_

Special Skills: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Dates Worked: \_\_\_\_\_

Type of Work: \_\_\_\_\_

Special Skills: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Dates Worked: \_\_\_\_\_

Type of Work: \_\_\_\_\_

Special Skills: \_\_\_\_\_

# Notes

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