THE POLLOCK GROUP CLIENT PERSONAL DATA SURVEY

Name _____ **Date** _____ **Date of Birth** _____

Occupation (if student, list school name & grade) _____

Marital/Partner Status _____ **Partner's Name** _____ **Age** _____

Partner's Occupation _____

Others living in your home:

Name	*Age*	*Sex*	*Relationship to Client*
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

What prompted you to call at this time?

List all current medications including over-the-counter medications:

_____

_____

_____

_____

_____

Date of last physical: _____

If you have a history of any of the following, please mark them with "**HX**"; mark any you are presently experiencing with "**PR**":

Head Injury	____	Seizures/Loss of Consciousness	____
Heart Trouble	____	Frequent/Severe Headaches	____
Thyroid Problems	____	Memory Problems	____
Cancer	____	Change in Sleep/Appetite	____
Eye Trouble	____	Shortness of Breath	____
HIV/AIDS	____	Undesired Change in Weight	____

Are you currently being treated for any medical condition(s) ____ Y ____ N

If yes, please indicate: _____

_____

_____

Please list reasons and approximate dates of any hospitalizations:

_____

_____

_____

Please list reasons and approximate dates of any previous therapy:

_____

_____

_____

_____

_____

Primary Care Physician's name and phone number:

_____

_____

Fatigue ____ High/Low Blood Pressure ____

Dizzy/Fainting ____ Stomach Problems/Ulcer ____

Confusion ____ Drug or Alcohol Problems ____

Suicidal Thought ____ Diabetes ____

Anxiety ____ Anemia ____

Stroke ____ Liver Disease ____

Depression ____ If child (to 18 years), are immunizations current? ____ Y ____ N

Other: _____

_____

FOR CLINICAL USE ONLY

___ Client was advised to seek medical treatment and/or physical examination.

___ Client is in active medical treatment.

Client's response to referral: _____

Clinician _____ Date_____