|  |  |  |
| --- | --- | --- |
| **Shelter** | **Time** | **Date** |
|  |  |  |

**Chief Complaint** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Client Information** | | |
| **Name:(Last, First)**  **Patient #** | | |
| **Age:** | **DOB:** | **Male\_\_\_\_\_ Female\_\_\_\_\_** |
| **Address:** | | |
| **City:** **State:** **Zip:** | | |
| **Emergency Contact Name & Number:** | | |
| **Caregiver Name & Number :** | | |

|  |
| --- |
| **Allergies** |
| **List all Medications, Environmental, and food allergies (include type of reaction)** |
|  |
|  |
|  |
|  |

|  |  |  |
| --- | --- | --- |
| **Medications** | | |
| **Current Medication** | **Dose** | **Last Dose** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **Medical History** |
|  |
|  |
|  |
|  |
|  |
|  |

**Client Name (First, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Document initial visit or treatment and each follow-up visit. Use medical terms;** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Staff Prints Name, signature, credentials, date and time