TRINITY COUNSELING SERVICES LLC
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Client Name_____Client Number_____

MEDICAL INFORMATION (Charlotte)

In the event of a medical emergency, the employees/representatives of Trinity Counseling LLC, have my permission to seek care for me from a hospital, physician or emergency services. I also give my permission to release medical information concerning me to any medic and/or pertinent hospital personnel and the contact person I have listed below

Emergency Contact_____Relationship_____Best Contact Phone_____

Name of Primary Physician_____Phone Number_____

Hospital Preference: ( )Carolinas Medical ( )Presbyterian ( )Mercy ( )Other____

The doctrine of informed consent has been explained to me and I understand the information to be released, the need for the information that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled or _____(date, event or condition of expiration). I further acknowledge that I understand that I may revoke this consent in writing at any time except to that extent that action based upon this consent has already been taken.

1 How would you describe your general health? _____

2 When was the last time you saw a doctor?_____Why?_____

3 Date of last hospital admission_____Why?_____

Do you have, or have you ever had, any of the following health problems?

	Yes	No		Yes	No		Yes	No
Diabetes			Headaches			Seizures		
Depression			Miscarriages			Migraines		
Suicide Attempt			PMS			Cancer		
Pancreatitis			High BP			STDs		
Vomiting Blood			Hepatitis			Colds		
Ulcers			Liver			Phy Impair		
Kidney			Lung			Stroke		
Chronic Diarrhea			Emphysema			Tuberculosis		
Blood in Stool			Heart			Other		
Other Abnormal Bleeding			Allergies List Below			Are You Pregnant?		

Use this space to explain any of the above conditions or other conditions you may have

_____

Are you taking any medications? If so, list below. Are you allergic to any medications?

_____

_____ _____

Client Signature(full legal name) Date Counselor Signature Date