CONFIDENTIAL HEALTH HISTORY

Sandy McClure
Administrative Assistant to
Young Harris College offices of
Student Counseling & Success Center
Phone: 706-379-5057
Fax: 706-379-4318
Email: smcclure@yhc.edu

Name: Last:_____**First**_____**Middle**_____

Birthdate: _____/_____/_____ **Gender**_____ **Semester/Year entering YHC**_____

Home Address_____

City, State, Zip_____

Home Phone (____)_____ **Student's Cell Phone**_____

Home Physician_____ **Phone**_____

Address_____

EMERGENCY CONTACTS (LIST 2)

1. **Name**_____**Relationship**_____

Address_____

Work # (____)_____**Home (____)**_____**Cell**_____

2. **Name**_____**Relationship**_____

Address_____

Work # (____)_____**Home (____)**_____**Cell**_____

ACKNOWLEDGEMENT AND AUTHORIZATION BY STUDENT AND / OR PARENT / GUARDIAN

All information given on this form is true to the best of my knowledge and I have no abnormality, limitation, or restriction not mentioned in this record. I agree to notify the Student Counseling Center of any change that may occur, whether such change occurs prior to my registration or while I am a student.
I understand that my counseling/health records are confidential. To have my records shared with others requires my written permission except if there is evidence of clear and imminent danger of harm to self or others, in which case, a counselor is legally required to report this to the appropriate persons in order to ensure safety.
PERMISSION is hereby granted to the Student Counseling staff for treatment of this student.

Student signature_____**Date**_____

Parent/Guardian signature (if student is under the age of 18)_____

Medication Allergies	**Food/Environmental Allergies**	**Current Medications & Dosage**

Sandy McClure
Administrative Assistant to
Young Harris College offices of
Student Counseling & Success Center
Phone: 706-379-5057
Fax: 706-379-4318
Email: smcclure@yhc.edu

Name:_____ **Date:**_____

Please check all that apply & Circle the main problem

Difficulty with:	You	Now	Past	Family
Anxiety				
Depression				
Drugs/Alcohol (specify)				
Suicide/Thoughts				
Hurting Self / Others				
Abuse (specify)				
Psychiatric Hospitalization				
Nervous Breakdown				
Fears/ Panic				
Excessive Worry				
Feeling Manic				
Communicating w/others				
Parents/Othes (specify)				
Sleeping too much/little				
Getting to sleep				
Waking too early				
Nightmares				

Difficulty with:	You	Now	Past	Family
Domestic Violence				
Sexual Concerns				
Legal Problems				
Trusting Others				
Concentration				
Irritability				
Anger or Temper				
Learning Disabilities				
Often makes mistakes				
Frequently fidgets				
Completing Tasks				
Paying Attention				
Easily Distracted				
Hyperactive				

Any additional information you would like to include that isn't listed that we need to be aware of:

_____

_____

_____

_____

_____