

Producer: _____

Client: _____

DOB: _____ Sex: _____

Height _____ Weight _____

Tobacco Use: _____

Crohn's Disease

Date of First Diagnosis: _____

Date of Last Flair -Up: _____

Medications: _____

Please check if your client has had:

- Hospitalizations for this disorder (list dates): _____
- Surgery for this disorder (list dates): _____
- Colonoscopy (list dates of most recent): _____

Details to Surgery/Major Medical Procedures:

Does Your Client Have Any Other Major Medical Problems?

- NO
- YES, Please Provide Details

If No Medications, please provide details as to why and how it is being controlled: _____

