CLIENT HEALTH HISTORY

Patient Name:_____

Person completing form (if other than patient):_____

Contact person in case of emergency: _____ **Relationship:** _____

Phone #:_____

Primary Care Physician: _____
Date of Last Exam: _____
Current Medical Condition(s):

_____

Are you currently taking any prescription or "over the counter" medication(s)? No___ Yes___
If Yes, please identify the name, current dosage, and date began for each: _____
_____
Do you have any allergies? No___ Yes___ If yes, please list: _____
_____
Have you received any Psychological/Psychiatric treatment before? No___ Yes___
If Yes, please show the total number of outpatient visits you have had: _____
What was your age at the first visit? _____
Have you had any inpatient/hospital treatment for mental health or substance abuse? No___ Yes___
[If Yes, please list facility(ies) date(s) and length(s) of stay(s)]: _____
_____
What caused you to get help now?
_____
_____
_____
Do you smoke cigarettes? No___ Yes___ If yes, how many per day? _____
How much alcohol do you drink per week on average? _____ drinks per week
Have you had problems with your drinking (legal, health, work, relationship?)
No___ Yes___ If Yes, please explain: _____
_____
Please answer whether or not you are experiencing any of the following symptoms:
Suicidal Thoughts/Impulses ..... N____ Y____
Homicidal Thoughts/Impulses ..... N____ Y____
Appetite Problems ..... N____ Y____
Sleep Problems ..... N____ Y____
Physical Complaints ..... N____ Y____
Anger/Irritability ..... N____ Y____
Isolation/Social Withdrawal ..... N____ Y____
Anxiety/Panic ..... N____ Y____
Phobia ..... N____ Y____
Bingeing/Purging ..... N____ Y____
Poor Impulse Control ..... N____ Y____
Violence Toward Others ..... N____ Y____
Destruction of Property ..... N____ Y____
Strange or Unusual Behavior ..... N____ Y____
Confused or Irrational Thinking ..... N____ Y____
Bothersome Repetitive Thoughts or Behaviors N____ Y____
Self-mutilation ..... N____ Y____