CLIENT HEALTH HISTORY

Client Name:_____

Marital Status:_____

Relationship:_____

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/vape? No___ Yes___ If yes, how many/much 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____