



Client Health Information

Name	Today's date
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Please briefly describe your reason(s) for seeking help.

MENTAL HEALTH TREATMENT AND FAMILY HISTORY

Outpatient treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Inpatient treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, did it help?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Where		
Therapist's name			Dates of treatment		
Dates of treatment					

Family history of mental/emotional/behavioral problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, who?		
Relationship to you:		

MEDICAL HEALTH STATUS AND HISTORY

List any medical or physical problems and when they were diagnosed.

List any major surgeries you have had to date.

List any serious illness or injuries you have had, especially anything involving your head.

List any food or drug allergies you have.

Date of your last physical examination:	Name of your physician:
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May we contact your physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician's contact information (address and phone)
See "Privacy Practices" statement for more information on releases of your information.	

CURRENT ISSUES

Please check any of the following that apply to you.

<input type="checkbox"/> Thoughts of suicide	<input type="checkbox"/> Thoughts of harming others	<input type="checkbox"/> Phobias
<input type="checkbox"/> Trouble getting to sleep	<input type="checkbox"/> History of suicide attempts	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Waking during the night	<input type="checkbox"/> Cutting or hurting yourself	<input type="checkbox"/> Excessive guilt
<input type="checkbox"/> Waking early almost every day	<input type="checkbox"/> Feeling hopeless	<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Financial problems	<input type="checkbox"/> Unable to make decisions	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Trouble controlling your temper	<input type="checkbox"/> Health problems
<input type="checkbox"/> Hearing non-existent voices	<input type="checkbox"/> Large unexpected weight gain or loss	<input type="checkbox"/> Family problems
<input type="checkbox"/> Problems at work	<input type="checkbox"/> Seeing things others don't	<input type="checkbox"/> Violence toward others
<input type="checkbox"/> Trouble concentrating	<input type="checkbox"/> Past or current physical abuse	<input type="checkbox"/> Tingling or numbness
<input type="checkbox"/> Racing thoughts	<input type="checkbox"/> Past or current sexual abuse or assault	<input type="checkbox"/> Depressed mood
<input type="checkbox"/> Legal problems	<input type="checkbox"/> Past or current emotional abuse	<input type="checkbox"/> Missing hours or days

PLEASE CONTINUE TO SECOND PAGE

SUBSTANCE USE

Please list all of the prescription and over-the-counter drugs you are taking and their dosages.

Please complete this chart based on the substances you use in any amount at all.

	Age of first use	Frequency/Quantities (How much and how often?)			
		Weekday	Weekend	Month	Last use date
Beer					
Spirits/Liquor					
Wine					
Marijuana					
Cocaine/Crack					
Methamphetamine/Crystal Meth					
Heroin					
Barbiturates (Downers)					
PCP, LSD (Hallucinogens)					
Tobacco (in any form)					
Other (please list)					

Adults (18 years of age and older) please answer the following questions.

Have you ever felt like you should cut down on our drug or alcohol use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has a friend or relative expressed concerns about your use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever felt guilty about your drinking or drug use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had to take a drink or use a drug the next day to steady your nerves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you a recovering alcoholic or a recovering drug addict?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there a history or problems with drug or alcohol use in your family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Adolescents (12 years to 17 years of age) please answer the following questions.

Have you ever used alcohol or drugs before or during school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever missed school (or been truant) because of use or just to use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever avoided non-users?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How often do you get drunk or high?		
About how often do you use more than one drug when you get high?		
Is there a history or problems with drug or alcohol use in your family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SIGNATURES

Client signature	Date	Clinician signature	Date
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