

**CLIENT HEALTH HISTORY**

**Patient Name:** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_

**Person completing form (if other than patient):** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Name of Guardian (if applicable):** \_\_\_\_\_

**Contact person in case of emergency:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**Date of Last Exam:** \_\_\_\_\_

**Current Medical Condition(s):**  
\_\_\_\_\_  
\_\_\_\_\_

**Any peri-natal or developmental abnormalities?** No \_\_\_ Yes \_\_\_ (Please explain on back of form)

**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 \_\_\_