# HEALTH HISTORY FORM

Please provide the following information below. Please note: information you provide here is protected as confidential information. However, some of these questions are of a sensitive nature, and you are welcome to answer them verbally and privately in our meeting. Please fill out this form and bring it to your first session.

Name: ______________________________________________________________
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):
______________________________________________________________

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: ______________________________________________

Address: ____________________________________________________________
(Street and Number)

______________________________________________________________
(City) (State) (Zip)

Home Phone: (          ) Cell/Other: (          )
May we leave a message? □ Yes □ No May we leave a message? □ Yes □ No

E-mail: ________________________________________May I email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____________________________________________________
Do I have your permission to thank this referral source? □ No □ Yes

Have you previously received any type of mental health services (psychotherapy, psychiatric services, group work, etc.)?
□ No
□ Yes, previous therapist/practitioner: _______________________________________

Are you currently taking any prescription medication?
□ Yes □ No
Please list: ____________________________________________________________
______________________________________________________________

Have you ever been prescribed psychiatric medication?
□ Yes □ No
Please list and provide dates: _____________________________________________
______________________________________________________________

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
______________________________________________________________________

2. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
______________________________________________________________________

3. How many times per week do you generally exercise? ___________
What types of exercise do you participate in? _______________________________________

4. Please list any difficulties you experience with your appetite or eating patterns:
______________________________________________________________________

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No □ Yes
If yes, for approximately how long? ______________________________________________

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No □ Yes
If yes, when did you begin experiencing this? ______________________________________

7. Are you currently experiencing any chronic pain?
□ No □ Yes
If yes, please describe: ____________________________________________________

8. Do you drink alcohol?
□ No □ Yes
If yes, how often: ________________________________________________________

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □Infrequently □Never

10. Are you currently in a romantic relationship?
□ No
□ Yes
If yes, for how long? ___________________
On a scale of 1-10, how would you rate your relationship? ___________

11. Have you ever experienced any of the following pregnancy related outcomes?
□ stillbirth □ectopic □miscarriage □abortion □extreme traumatic birth □premature birth

12. What significant life changes or stressful events have you experienced recently:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

| | Please Circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | ____________________ |
| Anxiety | yes/no | ____________________ |
| Depression | yes/no | ____________________ |
| Domestic Violence | yes/no | ____________________ |
| Eating Disorders | yes/no | ____________________ |
| Obesity | yes/no | ____________________ |
| Obsessive Compulsive Behavior | yes/no | ____________________ |
| Schizophrenia | yes/no | ____________________ |
| Suicide Attempts | yes/no | ____________________ |

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is the role and nature of your work?

______________________________________________________________________

Do you enjoy your work? Is there anything overly stressful about your current work situation?

______________________________________________________________________

______________________________________________________________________

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

______________________________________________________________________

3. What do you consider to be some of your strengths?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

4. What do you consider to be some of your weaknesses?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

5. What would you like to accomplish out of your time in therapy?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

6. Is there anything else that you would like me to know?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________