REDFORD COUNSELING CENTER

25935 West Seven Mile

Redford, MI 48240

COMPREHENSIVE BIO-PSYCH-SOCIAL HISTORY

FOR OFFICE USE ONLY

Date ________________

Time ________________

Case No: ________________

Please Print

Name ____

Address ____

City ________________________ State __________ Zip ____________

Telephone (Home) ____________________ Cell____________________

Work ________________________ e mail ________________________

If we contact you, may we identify ourselves as Redford Counseling Center?

At home: yes____ no____ Cell: yes____ no____ Work: yes____ no____

Social Security Number ______________________________

Sex: Male________ Female ________ Age ________ Date of Birth________________

Times available for Redford Counseling Center Appointments:______________________

Referral Source:____

Health Insurance: Yes_____ No_____ Type:____________________________________

Emergency Contact:

Name________________________________ Relationship to contact:_______________

Address____

City/State/Zip____

Cell/Work/Home Number __________________________________

Intake Revised 6/2017

REDFORD COUNSELING CENTER

MEDICAL ASSESSMENT

1. History of past or present illness (heart disease, high blood pressure, cancer, etc.), hospitalization and/or surgical procedures and dates.
   ____yes ____no If yes, explain: ______________________________
   ____

2. History of any serious injuries/accidents, including injuries to the head.
   ____yes ____no If yes, explain: ______________________________
   ____

3. Do you experience chronic pain?

   ____yes ____no If yes, how do you deal with it: ______________________
   ____

   Would you like a referral? _____yes_____no

4. Do you experience any difficulties sleeping?
   ____yes ____no If yes, describe: ______________________________
   ____

5. Do you have any current problems with anything listed below?

	YES	NO
SKIN		
EARS		
THROAT		
CHEST		
URINARY		
MUSCLES		
NERVES		

	YES	NO
EYES		
NOSE		
HEART		
STOMACH		
GENITAL		
BONES		

If yes, explain: ______________________________________
____
____

Revised 6/2017

Current Medication

Medication	Dosage	Frequency	Reason	Prescribing Physician

6. Are you allergic to any medication?

☐ no ☐ yes If yes, please specify: ______________________________

____

7. Any other allergies (e.g.insect bites, foods, clothing, etc)?

☐ no ☐ yes If yes, please specify:______________________________

____

8. Have you had any seizures?

☐ no ☐ yes If yes, explain type: ______________________________

____

9. Do you have or had any communicable diseases?

☐ no ☐ yes If yes, specify type: ______________________________

____

10. Are you pregnant?

☐ no ☐ yes If yes, how far: ______________________________

____

11. How would you rate your present state of health?

☐ good ☐ fair ☐ poor

SUBSTANCE ABUSE HISTORY

	Age of First Use	Age of Regular Use	Last Time Used (Date)	Number Times Used within Last 30 Days	Used within Last 48 Hours?	Amount/Frequency of use	Route of Admin.
Ecstasy					Y / N		
Heroin					Y / N		
Non-Rx Methodone					Y / N		
Other Opiates/Synthetics					Y / N		
Alcohol					Y / N		
Barbiturates					Y / N		
Tranquilizers					Y / N		
Other Sedatives, Hypnotics					Y / N		
Amphetamines					Y / N		
Cocaine					Y / N		
Crack					Y / N		
Marijuana/Hashish					Y / N		
Hallucinogens (specify)					Y / N		
PCP					Y / N		
Inhalants					Y / N		
Over-the-Counter Drugs					Y / N		
Psychotropics					Y / N		
Other(s) (specify)					Y / N		
Nicotine					Y / N		
Caffeine					Y / N		

Primary ______________________________

Secondary ______________________________

Tertiary ______________________________

Preference ______________________________

Redford Counseling Center

Suicide Risk Assessment

Client________________________________ **Date**________________

Instructions: Please check the number beside the statement or phase that best applies to you.

1. **Do you have any mental health disorders? (depression, bipolar disorder, anxiety,etc). If yes are you being treated for it? (i.e. taking medication or getting counseling)**

   _____Yes

   _____No

2. **Have you ever tried to kill yourself? (check one only)**

   _____Never

   _____It was just a brief passing thought.

   _____I have had a plan at least once to kill myself but did not try to do it.

   _____I have had a plan at least once to kill myself and really wanted to die.

   _____I have attempted to kill myself, but did not want to die.

   _____I have attempted to kill myself, and really hoped to die.

3. **Have you ever thought about killing yourself?**

   _____Yes

   _____No

4. **How often have you thought about killing yourself in the past year? (check one only)**

   _____Never

   _____Rarely

   _____Sometimes (2 times)

   _____Often (3-4 times)

   _____Very often (5 or more times)

5. **Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)**

   _____No

   _____Yes, at one time, but did not really want to die.

   _____Yes, at one time, and really wanted to die.

   _____Yes, more than once, but did not want to do it.

   _____Yes, more than once, and really wanted to do it.

Revised 05/2017 using information from U.S. Preventive Services Task Force

Redford Counseling Center

Hepatitis C Screening

Instructions: Please check yes or no.

	NO	YES
1. Have you ever injected any drugs?	____	____
2. Are you currently using any drugs by injecting them?	____	____
3. Did you ever have a blood transfusion before 1992?	____	____
4. Are you currently getting hemodialysis?	____	____
5. Did your Mother have Hepatitis when you were born?	____	____
6. Did you get a tattoo in an un-certified place? (Such as a home-made tattoo, or while being in prison).	____	____
7. Have you ever been to jail or prison?	____	____
8. Have you ever snorted any drugs?	____	____

Score_______

TB QUESTIONNAIRE

	NO	YES
1. Do you tire easily?	____	____
2. Have you lost weight without really trying?	____	____
3. Have you noticed a loss of appetite?	____	____
4. Do you sweat a lot at night?	____	____
5. Have you had a cough for more than three weeks?	____	____
6. Have you recently had a fever or chills that lasted longer than 3 days?	____	____
7. Do you cough up blood?	____	____
8. Have you noticed that your glands are swollen?	____	____
9. Have you had close or casual contact with someone who may have TB?	____	____
10. Have you ever had a TB skin test? Results: Circle one: Negative Positive	____	____

Score_______

If you answered yes to any of the above questions, you should take the first step to find out if you are infected with Hepatitis C or the TB germ. You can do this be getting tested at the Wayne County Health Department.

Revised 6/2017

AIDS QUESTIONNAIRE

	No	Yes
1. Do you have unusual, unexplainable fatigue or listlessness?	____	____
2. Do you have rapid unexplained weight loss of 10-15 pounds or 10% of body weight?	____	____
3. Do you have a persistent fever of 100 degrees or more?	____	____
4. Do you have recurrent drenching night sweats?	____	____
5. Do you have swollen lymph nodes outside of groin area?	____	____
6. Do you have chronic unexplained diarrhea?	____	____
7. Have you shared unsterile needles/syringes-or any part of "works" during the two years?	____	____
8. Have any of the persons with whom you have shared needles been inflected with HIV, ARC or AIDS?	____	____
9. Have any of your sexual partners over the last two years been members of groups at high risk for AIDS?	____	____

If so, place a check after the appropriate group:

____ Other IV drug users
____ Sexual partners of these groups
____ Gay or bisexual males
____ Hemophiliacs/transfusion recipients

10. Have any of these "at risk" sexual partners become infected with HIV or have been diagnosed with ARC or AIDS?	____	____
11. Have you had any potentially risky blood-exchanging procedures within the last two years?	____	____

If yes, which of the following did you have?

____ Blood Transfusions
____ Tattoos
____ Ear-piercing by a non-professional

Score ______________

If you answered yes to two or more of the above questions, you should take the first step to find out if you are infected with HIV. You can do this by getting tested at the Wayne County Health Department.

July 2011

REDFORD COUNSELING CENTER

HEALTH SUMMARY

Do you smoke now? _____yes _____no

How much do you smoke? ________________

Would you like to quit? _____yes _____no

Do you take vitamins, supplements, over the counter medications?

If yes please list: ____

No____

Do you eat sweets regularly? _____yes _____no

Do you eat fatty food regularly? _____yes _____no

Do you eat vegetables regularly? _____yes _____no

Have you lost or gained weight in the last year without trying? _____yes _____no

When was your last dental exam?____________

When was your last vision exam?_____________

When was your last physical exam?___________

Your weight___________ Your height_____________

Name of your primary care physician____

Address____

Phone Number____

Client_____________________________________Date_______________________

Revised 6/2017