Health History Intake Form

(Each person seeking counseling needs to fill out this form)

Name: _____ Age:_____ Telephone: ____ - _____-_____

Address: _____

City: _____ State: _____ Zip: _____ e-mail: _____

Insurance Company (If Applicable) _____

Date of Birth: _____ ID Number: _____

Authorization Number: _____ Group Number: _____

Co-Pay Amount: _____ SS# _____ ____ _____

Education: _____

Highest grade completed; _____ Degree (s) earned: _____

Previous History of Marriage/Divorce:

_____

Vocation: Present _____

Past: _____

1. Are there any addictive problems in your family history (alcohol, drugs, etc.)?

2. Is there any history of mental illness? Please describe.

3. Please indicate if you have any history of the following ailments in your family:

___Tuberculosis
___Heart Disease
___Diabetes
___Cancer
___Ulcers
___Glandular Problems

___Other(s) _____

4. How would you describe your concern for:

   Diet:

   Exercise:

   Rest:

5. Who lives in your household? Names, ages, relationships.

6. Why are you seeking help?

7. Are you presently under any kind of medication for either physical or psychological reasons? Explain.

8. Past history of Psychotherapy or Psychiatric Treatment

9. Describe your past and present substance abuse.

10. Have you ever experience any type of trauma; i.e., physical, emotional, or sexual history of abuse, involvement in a severe accident, death of family member, etc.? Explain

11. Describe any symptoms you may be having. Examples are; Depressed, sleep problems, relationship problems, panic attacks, confused or troubling thoughts, compulsive behaviors, suicidal thoughts, etc.