H.I.S. COUNSELING – MEDICAL / MENTAL HEALTH HISTORY AND SCREENING

Client Demographic Information:

Name:_____ Age: _____ Date of Birth:_____

Marital Status:

___ Single ___ Married ___ Separated ___ Divorced ___ Widowed

Sex:

___ Male ___ Female

Highest Education Level:

___ Grade School ___ Jr. High School ___ High School ___ College ___ Graduate School

Occupation:

Employer: _____

Family Physician and/or Primary Health Care Provider:

Doctor/Provider: _____ Phone #: _____

Address: _____

Current Mental Health Care Provider:

Doctor/Provider: _____ Phone #: _____

Address: _____

Previous Diagnosis: ___ ADD/ADHD ___ Anxiety ___ Bi-Polar ___ Depression ___ OCD ___ PTSD ___Schizophrenia Other: _____

May we send information regarding your treatment to your physician or mental health care provider and consult with them as necessary?

___ Yes ___ No

Signature (legal guardian if under 18): _____

What is your goal for treatment?

_____

_____

Medical / Mental Health History:

How would you rate your current PHYSICAL health?

___ Excellent ___ Good ___ Fair ___ Poor

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How would you rate your current MENTAL / EMOTIONAL health?

___ Excellent ___ Good ___ Fair ___ Poor

Check if you currently or recently experienced symptoms:

___ Have you had a Traumatic Brain Injury (TBI) or any head injuries?
___ Do you have any hearing problems?
___ Do you have any vision problems?
___ Do you often have a pulmonary condition (difficulty breathing)?
___ Do you have a GI / bowel condition?
___ Do you have a thyroid condition?
___ Do you have a heart condition?
___ Do you have diabetes?
___ Do you have increased anxiety or depression?
___ Do you have problems with fatigue or trouble sleeping?
___ Do you experience increased irritability?

If yes, please describe any current or past medical conditions:

_____
_____
_____
_____

Medications:

Please list all CURRENT/Recent Medications:

Medication: _____ Dose: _____
Condition: _____ Date Started: _____
Medication: _____ Dose: _____
Condition: _____ Date Started: _____
Medication: _____ Dose: _____
Condition: _____ Date Started: _____
Medication: _____ Dose: _____
Condition: _____ Date Started: _____
Medication: _____ Dose: _____
Condition: _____ Date Started: _____

Please list OVER THE COUNTER medications you are currently taking and frequency: _____

_____

Please list any DIETARY SUPPLEMENTS or vitamins you are currently taking and frequency: _____

_____
_____

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Check any substances current or previous use:

Alcohol / Drug	Age @ First Use	Frequency – Amount	Last Use:
Beer			
Vodka			
Whiskey			
Wine			
Other:			
Benzo's			
Fentanyl			
Heroin			
Marijuana			
Meth			
Opiates			
Other:			

Longest period of sobriety: _____

Please list any substance abuse treatment programs attended: _____

_____

_____

Please list any MENTAL HEALTH HOSPITALIZATIONS, including dates of and reasons for: _____

_____

_____

Over the past few weeks how often have you been experiencing the following:	**Not at all**	**Several days**	**More than half the Days**	**Nearly Every Day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you have let yourself or your family down	0	1	2	3
Trouble concentrating	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself or others in some way	0	1	2	3

_____ _____

(Signature): Date