Health Form

Name:____ **Date:**_________________

Any current medical problems? ____ Y ____N Describe:____
____

Any history of medical problems? ____ Y ____N Describe:____
____

Do you have a Primary Care Physician? ____ Y ____N PCP Name:______________________________
Do you take any prescription medications? ____ Y ____N Name/Dosage:_____________________________________
____

Current psychiatric medications? ____ Y ____N Doctor Name:_____________________________________
Name/Dosage:_____________________________________
Has a doctor ever prescribed mediations for mood, anxiety, or depressive symptoms? ____ Y ____N Doctor Name:_____________________________________
Name/Dosage:_____________________________________
Do you smoke? ____ Y ____N Amount/Frequency:______________________________
Do you drink alcohol? ____ Y ____N Amount/Frequency:______________________________
If yes…
Have you ever tried to cut down on your drinking? ____ Y ____N
Are you annoyed when people ask you about your drinking? ____ Y ____N
Do you ever feel guilty about your drinking? ____ Y ____N
Do you ever take a morning eye-opener? ____ Y ____N Describe:______________________________

Daily consumption of caffeine? ____ Y ____N Amount:_____________________________________
Do you use any non-prescription drugs on a regular basis? ____ Y ____N Name/Amt/Freq:_____________________________________
____
Any history of accidents or head injury? ____ Y ____N Describe:____
____

Any current problems with eating/appetite? ____ Y ____N Describe:____
Any changes in weight recently? ____ Y ____N # lbs. gained ________ # lbs. lost ________
Any current problems with sleep/waking early? ____ Y ____N Hours of sleep per night: _________________
Have any family members ever been in treatment for mental health problems or chemical dependency or would you suspect any of these problems to have existed with family members? ____ Y ____N Relationship:_____________________________________
Describe:____
____

Previous Mental Health Treatment (check all that apply):
____ None
____ Out Patient Therapy:
1) Provider Name:___________________________
When/Duration:______________________________
Focus:______________________________________
2) Provider Name:___________________________
When/Duration:______________________________
Focus:______________________________________
3) Provider Name:___________________________
When/Duration:______________________________
Focus:______________________________________

____ Inpatient Treatments:
Facility:____________________________________
When/Duration:______________________________

Previous Substance Abuse Treatment (check all that apply):
____ None
____ Outpatient Treatments:
1)Provider Name:_____________________________
When/Duration:_______________________________
Outcome:____________________________________
2) Provider Name:____________________________
When/Duration:_______________________________
Outcome:____________________________________
3) Provider Name:____________________________
When/Duration:_______________________________
Outcome:____________________________________

____ Inpatient Treatments:
Facility:_____________________________________
When/Duration:_______________________________
____ Self-help:_____________________________________