HEALTH HISTORY AND CLIENT INFORMATION

Please complete this form and bring it with you to your first session.

Name	Age	Date of Birth	Place of Birth

Address (include zip)	Living with others?	Ethnicity/Race

Marital Status □ Never married/partnered □ Married/partnered □ Separated/divorced/widowed	Name of Spouse/Partner	Children/Ages

Sexual Orientation	Education	Occupation

Employment Status □ Employed full time □ Employed part time □ Not employed outside home	Current Employer	Referred by: May I thank them for the referral? □ Yes

Emergency Contact Name (and their relationship to you)	Emergency Contact Phone

Home phone ( ) _____ Is it OK to leave a message? □ No □ Yes

Cell phone ( ) _____ Is it OK to leave a message? □ No □ Yes

Work phone ( ) _____ Is it OK to leave a message? □ No □ Yes

e-mail _____ Is it OK to email you? □ No □ Yes

Are you currently in a romantic relationship? □ No □ Yes: length of current relationship _____

On a scale of 1 to 10 (10 best) how would you rate the quality of your current relationship? _____

Do you exercise regularly? □ No □ Yes How many hours do you sleep at night? _____

How would you describe your physical health? □ Excellent □ Good □ Fair □ Poor

In the past year have you experienced any significant life changes or stressors? _____

_____

_____

What concerns have brought you to seek therapy at this time? _____

_____

_____

_____

		Please Provide Details
Any significant medical problems (now or past)?	□ No □ Yes	
Any chronic or recurring health problems?	□ No □ Yes	
Any serious injuries, hospitalizations or surgeries?	□ No □ Yes	
Have you ever been in a physical fight that resulted in injury (for you or someone else)?	□ No □ Yes	
Are you currently taking <u>any</u> medications?	□ No □ Yes	
Have you used psychiatric/psychotropic medications in the past?	□ No □ Yes	
Do you currently drink alcohol?	□ No □ Yes	
Do you currently use recreational drugs?	□ No □ Yes	
Have you ever had problems with substance use (alcohol, prescription medications, other drugs)?	□ No □ Yes	
Have you ever had feelings or thoughts that you didn't want to live?	□ No □ Yes	
Do you currently have thoughts of not wanting to live?	□ No □ Yes	
Have you ever tried to harm or kill yourself?	□ No □ Yes	
Any family members with psychiatric illness or substance use/abuse problems?	□ No □ Yes	
Do you have problems sleeping?	□ No □ Yes	
Any current or past problems/concerns about eating issues?	□ No □ Yes	
Any past problems with mood (such as anxiety, depression, anger)?	□ No □ Yes	
Any previous psychotherapy?	□ No □ Yes	
Any other significant medical/mental health history?	□ No □ Yes	
Do you have a history of being abused emotionally, sexually, physically or by neglect?	□ No □ Yes	
Have you ever been arrested?	□ No □ Yes	
Have you ever been exposed to traumatic events such as natural disasters or violence?	□ No □ Yes	
Have you ever been diagnosed or treated for a learning disability?	□ No □ Yes	
Are you currently under the care of a psychiatrist or other mental health practitioner?	□ No □ Yes	Name:
Do you have a primary care provider (such as physician, nurse practitioner, physicians assistant)?	□ No □ Yes	Name: