CLIENT HEALTH & INFORMATION

______________________ ______________________ __________ __________
Last Name First Name DOB Social Security #

SEX: M F Yrs. of Education ____ #Marriages ___ Married __ Divorced __ Widowed ___ Single ___Children? (#, ages) (___)_______

1. I am seeking help ***at this particular point in time*** ***because*** ________________________________

____

____

2. My problem began **within**: ___ the last month ___ last 3 mos. ____ last 6 mos. ___last 12 mos. ___ over one year ago

3. List all current medications: ____

4. List all medications taken in the past for emotional/psychiatric reasons (**include dates if possible)**

____

5. List all past or present mental health treatment:

Dates **Type of Treatment** **Dr./therapist's name & Where**

Previous suicide attempts: Date

6. Are you allergic to any medications? ___ NO ___ YES (specify) ____________________________

7. Mark X by any of the following if they have ever applied to you:

MENTAL HEALTH

__juvenile delinquency __running away __ truancy __ behavior problems
__family problems __ teenage pregnancy __
__school phobia __ childhood fears __ bedwetting ___panic attacks/anxiety
__hyperactivity __ inattention __ school or learning problems
__anorexia __bulimia __ binge eating __alcohol/drug problems
__emotional abuse __ physical abuse __ sexual abuse __ incest __ rape
__sexual problem __ sexual identity confusion __ criminal history

MEDICAL MILITARY HISTORY ____

__liver disease __ kidney disease __pancreatitis
__mononucleeosis __epilepsy __ thyroid disease __cancer
__heart trouble ___diabetes __venereal disease __AIDS or HIV+

List any other medical problems you have not listed above: ______________________________

8. Please list any significant **medical problems or mental illnesses** suffered by your parents, children, brothers and sisters, or grandparents, including Alcoholism, Chemical Dependency, Depression, etc.

____

9. Current Alcohol or illegal drug use (include recreational drugs, e.g. marijuana):

TYPE: ______________________________ **Frequency:** ______________________________
Last Use:______________________________ **Amount:** ______________________________

10. Current tobacco use (**Type, Quantity)**____

11. Current caffeine use (**Type, Quantity)**
____

Below is a list of problems and complaints that people sometimes have.
Please select the answer that *best* describes how you have felt ***during the past month, including today.***

	Never	Rarely	Sometimes	Frequently	Almost Always
I have trouble sleeping- too much or too little					
I feel no interest in things					
I feel stressed at work, school, home or other daily activities					
I have experienced (circle any applicable): pains in my chest or heart; faintness or dizziness; hot or cold spells; trouble catching my breath; nausea or upset stomach; numbness or weakness in my body; feeling like I am going crazy; mind going blank; heart pounding or racing; scared for no reason					
I feel irritated					
I have urges to beat, injure or harm someone, or smash things					
I feel something is wrong with my mind					
I have frequent arguments					
I need less sleep than usual					
My mind has never been sharper					
I have more plans and new ideas than I can handle					
I have been particularly happy					
I talk so fast it's hard for people to keep up with me					
I have been thinking about sex					
I have been spending too much money					
My attention keeps jumping from one idea to another					
I find it hard to slow down and stay in one place					
I have difficulty concentrating					
I feel hopeless about the future					
I have thoughts of ending my life					
I feel worthless					
I use alcohol or a drug to get going in the morning					
Disturbing thoughts come into my mind that I cannot get rid of					
People criticize my drinking or drug use					
I can drink more alcohol than most people before it affects me much.					
I have difficulty making decisions					
I feel guilty					
I am eating more or less than I used to (not due to dieting)					
I have to repeat the same actions, e.g. counting, washing					
I have to check and double check					

MASTER REGISTRATION INFORMATION

EMAIL ADDRESS: ______________________________

***CLIENT*: (PERSON BEING SEEN):**

____
LAST NAME FIRST MI NICKNAME

____
ADDRESS STREET CITY STATE ZIP

____
SOCIAL SECURITY # DATE OF BIRTH

____
PHONES: HOME CELL WORK

EMERGENCY CONTACT: ______________________________
NAME ADDRESS PHONE

PARENT OF CONTACT PERSON (IF APPLICABLE)

NAME______________________________
LAST FIRST MI NICKNAME
ADDRESS______________________________
STREET CITY STATE ZIP
PHONE: ______________________________
HOME CELL WORK

INSURANCE INFORMATION

PRIMARY INSURED PERSON (IF OTHER THAN CLIENT)

NAME______________________________
LAST FIRST MI NICKNAME
ADDRESS______________________________
STREET STATE ZIP
PHONE:______________________________
HOME CELL WORK

SOCIAL SECURITY #______________________ MALE / FEMALE **DATE OF BIRTH**: _______

INSURANCE COMPANY: ______________________________
NAME PHONE(S)

____
CLAIMS ADDRESS CITY STATE ZIP

EMPLOYER: ______________________________

SECONDARY INSURANCE: ______________________________
COMPANY NAME PHONE
POLICYHOLDER______________________________
LAST FIRST MI MALE / FEMALE
SOCIAL SECURITY #______________________ DATE OF BIRTH __________ PHONE: __________