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Client Name:____

Client Health and Mental Health Information Form

Please complete this form to the best of your ability.

1. How would you rate your current physical health? (please circle)

   Very Good   Good   Satisfactory   Unsatisfactory   Poor

   Please list any current medical conditions:_____________________________________

   ____

2. How would you rate your current mental health? (please circle)

   Very Good   Good   Satisfactory   Unsatisfactory   Poor

   Please list specific mental health issues you are currently experiencing:_______________

   ____

3. How would you rate your current sleep habits? (please circle)

   Very Good   Good   Satisfactory   Unsatisfactory   Poor

   Please list any specific sleep problems you are currently experiencing: _______________

   ____

4. How would you rate your current eating habits? (please circle)

   Very Good   Good   Satisfactory   Unsatisfactory   Poor

   Please list any difficulties you experience with your appetite or eating patterns: ________

   ____

5. How many times per week do you generally exercise? _____________________________

   What types of exercise do you participate in? ___________________________________

6. Do you consider yourself to be spiritual or religious? ______________________________

   If yes, please describe your faith or belief ______________________________________

7. Have you previously received any type of outpatient mental health services? Check all that apply:

   _____Psychotherapy _____Counseling _____Group Therapy
   _____Psychiatry _____Marital Therapy _____ Other

   If checked, please list:

Name	Dates Seen	Reason
___________________________________	__________	____________________________
___________________________________	__________	____________________________
___________________________________	__________	____________________________

8. What significant life changes or stressful events have you experienced recently (e.g., recent divorce, work stress, severe financial strain, death of friend or family, etc.)?

   ____

   ____

9. Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
___________________________________	__________	____________________________
___________________________________	__________	____________________________
___________________________________	__________	____________________________

10. Please list any prescription medication(s) you are currently taking:

Medication	Dosage	Prescribing Professional
_________________________________	_________	____________________________
_________________________________	_________	____________________________
_________________________________	_________	____________________________
_________________________________	_________	____________________________

Behavioral Checklist:

Please check the experiences you have had in the last two weeks, four months, or at some point in your life:

	In the last 2 weeks	In the last 4 months	At some point
I had panic attacks			
I experienced overwhelming sadness, grief, or depression			
I missed work or school			
I had trouble sleeping (going to sleep, staying asleep, waking up, nightmares)			
I weighed less than other people thought I should			
I lost control of my eating (binge eating, self-induced vomiting, etc.)			
I had sexual encounters of which I was ashamed or angry			
I experienced anxiety that interfered with my life			
I felt isolated from family/friends			
I lost control of my anger (yelling, hitting, breaking things, etc.)			
I thought/talked about wanting to kill myself			
I attempted suicide			
I injured myself on purpose (cutting, etc.)			
I avoided situations/people that made me uncomfortable			
I had thoughts that I could not get out of my head			
I repeated behaviors over and over in a row when I would like to stop			
I ran away from home			
I was fired from a job/suspended from school			
I was afraid for my life			
I experienced chronic physical pain			
I felt forces outside of me controlled me			
I felt that other people controlled my thoughts			
I had the same thought over and over and could not control it			
I had blackouts			
I had thoughts about hurting someone else			
I drove recklessly (excessive speeds, driving when drunk/high, etc.)			
I heard voices even though no one nearby was talking to me			
I felt that someone was out to hurt me or do something against me			

Do you drink alcohol? Yes / No (circle one)
If yes, how many drinks do you have per week? ____

Do you smoke cigarettes? Yes / No (circle one)
If yes, how many cigarettes do you smoke? Per day____________ Per Week_________________

Do you use any recreational drugs? Yes / No (circle one)
If yes, which ones?_________________________ How often? ____________________________

Family Mental Health History:

In this section, please identify if there is a family history of any of the mental health issues listed below. If yes, please indicate the family member's relationship to you in the space provided (father, mother, brother, sister, grandparent, uncle, etc.):

	(Please Circle)	Family Member
Depression	Yes / No	________________________________
Anxiety	Yes / No	________________________________
Eating Disorders	Yes / No	________________________________
Obesity	Yes / No	________________________________
Alcohol/Substance Abuse	Yes / No	________________________________
Domestic Violence	Yes / No	________________________________
Obsessive Compulsive Behaviors	Yes / No	________________________________
Schizophrenia	Yes / No	________________________________
Suicide Attempts	Yes / No	________________________________
Suicide	Yes / No	________________________________
Other	Yes / No	________________________________

Additional Information:

Is there any other information regarding you or your family that you would like to share with me that is not covered in this form?