HOLISTIC MENTAL HEALTH

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CLIENT INFORMATION Date________

Full Name: First ____________________________ MI _____ Last______________________________

Address (including zip code):

____

Phone: (_____) ____________ - ____________ Cell (_____) ____________ - _______________

Email Address: ____

May we leave a message on home phone? Yes No Cell phone? Yes No Email? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication

What is your preferred method for receiving correspondence? This includes weekly appointment reminders and other useful information.

Circle one: Phone contact Text messages Email only Facebook/Social Media

Date of Birth: _____/______/______ Age: ________ Gender: □ Male □ Female

Emergency contact: ________________________Phone of contact person: _____________________

Referral Source: (circle one) Vocational Rehabilitation VR Counselor____________________________

Self Friend Internet Psychology Today TV Commercial Other: ______________________________

Do you have a primary care physician? Yes No Name and phone: ____________________________

Do you have a Psychiatrist? Yes No Name and phone: ____________________________

List Any Medication Allergies: ____

Please list all medications you are currently taking and dosage if known:

Medication #1: ____________________________ Dosage: _________

Medication #2: ____________________________ Dosage: _________

Medication #3: ____________________________ Dosage: _________

Medication #4: ____________________________ Dosage: _________

Please list any Over the Counter medications, vitamins or herbal supplements you are taking:

____

Name current/previous psychiatrist: _________________________Phone (____) _______- _______

Mark areas of your concern with scale of severity:

Depression (low) 1 2 3 4 5 6 7 8 9 10 (high)

Anxiety/Panic Attacks (low) 1 2 3 4 5 6 7 8 9 10 (high)

Mood Swings (low) 1 2 3 4 5 6 7 8 9 10 (high)

Anger Outbursts (low) 1 2 3 4 5 6 7 8 9 10 (high)

Difficulty with Attention/Focus (low) 1 2 3 4 5 6 7 8 9 10 (high)

List any Mental Health Diagnosis if known:

Diagnosis #1: __________________________ Diagnosis #3: __________________________

Diagnosis #2: __________________________ Diagnosis #4: __________________________

Main purpose of your consultation (please give a brief summary of the main problems):

____

____

____

Have you received therapy services in the past? Was therapy helpful? Yes No Why?

____

History of any psychiatric hospitalizations (dates and how long):

____

____

____

History of Suicide Attempts Yes No Dates, how many times, method:

____

Self Injurious Behaviors? Yes No ____

Any serious losses in your life? Yes No ____

History of Substance Abuse: Yes No

If yes check all that apply, method of ingestion (where applicable) and length of use.

- Alcohol ___________________________ Methadone ___________________________
- Marijuana _________________________ Methamphetamine _____________________
- Cocaine ___________________________ Xanax ________________________________
- Opiates ___________________________ Ecstasy ______________________________
- Inhalants __________________________ Other ________________________________
- Nicotine ___________________________ How Many packs per day _________________

Any other Addictive behaviors? Yes No

Eating ____

Gambling ____

Video/Computer Games ____

Sexual Behavior ____

LEGAL HISTORY

Do you have a legal history of misdemeanor or felony law violations? Yes No

If yes please list charges and sanctions including incarcerations and probations including dates:

____

____

Are you currently on probation? Yes No Do you have any pending court appearances? Yes No

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RELATIONSHIPS

Any Religious or Spiritual beliefs/practices? Yes No ____

Briefly describe your following relationships:

Relationship with Natural Mother: Excellent Good Fair Poor

Mother have history of substance abuse? Yes No Mental Health? Yes No ______________________

Relationship with Natural Father: Excellent Good Fair Poor

Father have history of substance abuse? Yes No Mental Health? Yes No ______________________

Relationships with Step Mother/Father: Excellent Good Fair Poor

Either have history of substance abuse? Yes No ____

Where are you in birth order of siblings: Oldest Middle Youngest

How many siblings do you have? ___________ Mental Health History? Yes No

Please identify family history of any of the following (m=mother f=father s=sibling r=relative)

Alcohol/Substance Abuse	yes no	m f s r
Anxiety	yes no	m f s r
Depression	yes no	m f s r
Eating Disorders	yes no	m f s r
Obesity	yes no	m f s r
Obsessive Compulsive Behavior	yes no	m f s r
Schizophrenia	yes no	m f s r
Suicide Attempts	yes no	m f s r

Do you have a history of Childhood physical abuse? Yes No

Do you have a history of Childhood sexual abuse? Yes No

Do you have a history of Childhood emotional abuse? Yes No

Do you have a history of Childhood neglect? Yes No

Do you have a history of Foster Care or placements outside the home? Yes No

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Do you have a history of Rape or Molestation? Yes No

Do you have a history of Domestic Violence or have you witness Domestic Violence? Yes No

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Are you currently involved in a relationship? Yes No

If yes, do you feel threatened or otherwise have any concerns for your safety? Yes No

How would you describe your relationship with your significant other: Excellent Good Fair Poor

Any Children? Yes No Describe your family structure (who lives in your current household & relationship to each)

Do you have Close Friends? Yes No Do you engage in any social activities?

____

EMPLOYMENT

Are you currently employed? Yes No Occupation:_______________________________________

Overall Describe relationships with co-workers/supervisors:

Excellent Very Good Good Poor Very Poor

Have you ever been fired from an employer? Yes No # of times: _____

____

Do you change jobs frequently? Yes No ___________________________

If in Vocational Program what is your desired Vocational Goal?

____

Does your current mental health or physical health affect your ability to work? Yes No

Briefly Describe limitations:
____

____

If you are currently not working how long since you have been employed? ___________________

Education Highest Grade Completed including vocational training: ________________________

PERSONAL HABITS

How many hours per night do you sleep on average? _____Do you have any medical conditions affecting your sleep? Yes No ____

Do you wake feeling rested? Yes No Do you experience difficulty falling asleep? Staying asleep? Both?

Do you take any over the counter sleep aids? Yes No ____________________________________

Do you regularly have difficulty with worrisome or racing thoughts interfering with sleep? Yes No

Usual time to bed: ____________ Usual time to wake: ___________

Do you take naps? Yes No Do you sleep with Radio? Yes No TV? Yes No Computer? Yes No

How many ounces of water intake do you have on average per day? 1 glass=8oz

None 8-16oz 24-32oz 40-48oz 56-64oz 72-80oz 88+oz

Please list in order of largest to smallest quantities all other fluid intake including alcohol:

Most #1: ___________________ #2: ___________________#3: ___________________

How would you describe your overall health?

Excellent Very Good Good Average Poor Very Poor

Do you have a history of **Head Trauma**? Yes No Are you experiencing **Chronic Pain**? Yes No

If yes how long? ____________ Are you taking pain medication? Yes No

Briefly Describe: ____

____

List any current or past medical conditions you are or have experienced:

Current: ____

Past: ____

Avg # of Bowel Movements per day or week (circle one) ______ Height: ______ Weight: ________

Avg number of times you eat per day including snacks: ________

Do you regularly eat breakfast? Yes No

Usual breakfast foods: ____

Do you regularly eat lunch? Yes No

Usual lunch foods: ____

Do you regularly eat dinner? Yes No

Usual dinner foods: ____

Avg number of fruits/fruit juices per day: _______Avg number of veggies/veg juices per day: __________

Usual snack foods: ____

Average number of times you eat restaurant food per week: ___________ Fast Food _______

Any known vitamin deficiencies you have experienced including iron? ____________________________

What are your expectations/goals for treatment?

Goal #1

____

Goal #2:

____

Goal #3:

____