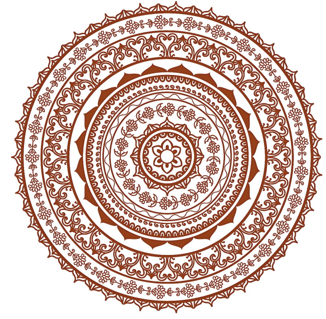
The Center for The Healing Arts & Sciences



Health Information Form

A. Identification

Name: ________________________________ Date:___________________ D.O.B______________

Address:____City: ______State:_____ Zip:__________

Home Phone: (____)__________________Cell Phone: (____)___________________________________

Email: ____

Which phone number is the preferred method by which I may contact you? ___________________________

If need be, when I call this number may I leave a message? Yes or No

Employer:___________________________________Occupation:_______________________________

Marital Status (circle one): Never Married Married Domestic Partnership Divorced Separated Widowed Preferred

Preferred Pronoun: __________________

Emergency Contact

Contact Name:_______________________________ Relationship_____________________________

Home Phone: (____)______________________Cell phone: (____)_____________________________

Referred by: ____

Reason for referral: ____

Have you seen any other psychologist, social worker, psychotherapist, counselor, or
psychiatrist in the past? If yes, give name, address, dates seen, and a brief description for the terms of care.

____

____

____

____

B. History

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, learning disabilities, IEPs, developmental delays and any other medical conditions you have had.

____
____
____
____

2. List *all* medications, drugs, or other substances you take or have taken in the last year - prescribed, over-the-counter vitamins, herbs, and others. Medication/drug Dose (how much?) Taken for Prescribed and supervised by:

____
____
____
____

C. Family History

Please identify any useful information regarding family history related to these topics. If yes, please indicate the family members relationship to you in the space provided (ex. mother, grandfather, cousin, etc.)

	Please Circle	List Family Member
Alcohol Use	Yes / No	________________
Substance/Drug Use Anxiety	Yes / No	________________
Depression	Yes / No	________________
Domestic Violence	Yes / No	________________
Eating Disorders	Yes / No	________________
Suicide Attempts	Yes / No	________________
Schizophrenia	Yes / No	________________

D. Health habits

1. What kinds of physical exercise do you get?

____
____

2. How much coffee, soda, tea, or other sources of caffeine do you consume each day?

____
____

3. Do you try to restrict your eating in any way? How? Why?

____

____

4. Do you have any problems getting enough sleep?

____

____

E. Chemical Use Survey

In order to treat you effectively, I need information about the ways you and your family have used alcohol, drugs, and/or other chemicals that can affect you psychologically. So please answer these questions fully.

1. What have you used? Think about any and all chemicals you have used, and indicate how much you used (amount) and how often.

Chemical:____ Estimated date of first and last use:____

Chemical:____ Estimated date of first and last use:____

Chemical:____ Estimated date of first and last use:____

Chemical:____

Estimated date of first and last use:____

Chemical Use additional comments :________________________________

____

____

____

____

2. Which of these have you had?

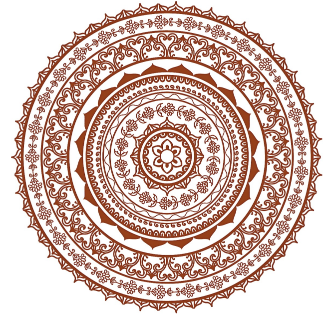
❑ Blackouts ❑ Bad reactions ❑ Withdrawal symptoms ❑ Overdoses ❑ Detoxification in a hospital

❑ Other problems:

____

____

____



Treatment for chemical use

1. Please provide any Dates, Agency/Provider, Type of program, Voluntary? (Yes or no) Length of treatment, Participation in aftercare programs (No/Which?) Effects of treatment:

____
____
____
____

Self-description of use

1.Would you say you ❑ are a social drinker ❑ are a heavy drinker ❑ have alcoholism or ❑ have a drinking problem? Or how would you describe your use?

____
____
____
____

2.Would you say you ❑ are a recreational drug user ❑ have an addiction or ❑ have a drug problem?

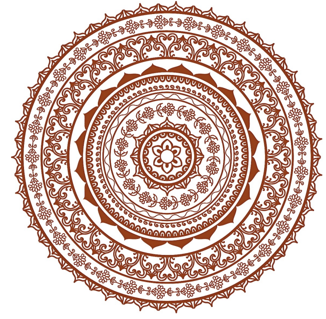
Or how would you describe your use?

____
____
____
____

Other

Has your drinking/drug use caused you any spiritual problems? If yes, please describe.

____
____
____
____
____



F. Additional Information

What concerns or issues bring you to therapy:

___

___

___

___

What changes do you hope therapy will lead to?

___

___

___

___

Is there anything that you want to change about yourself?

___

___

___

___

How will therapy help you make these changes?

___

___

___

___

What are your major strengths? (Abilities, resources, education, employment, personality, feelings, habits, relationships.)

___

___

___

___