The COUNSELING CENTER of Wayne & Holmes Counties

Client Health and Social History - Psychiatric Services

Name_____ Preferred Name_____

DOB_____ Biological sex: Male Female Other

Today's Date _____ Reason for Appointment _____

Who referred you to us/how did you hear about our agency?

_____

Please answer the below questions to the best of your ability. Your responses are confidential and kept as a part of your medical record. If you are unsure, answer to the best of your ability. ***If you need help with this form or have questions, please let the receptionist know.***

Physical Health History

Do you have a primary care provider? YES NO If yes, PCP name: _____

Have you ever been diagnosed with any of the following?

- ☐ Heart issues (high /low blood pressure, heart failure, heart attack, etc.)
- ☐ Lung issues (asthma, emphysema, COPD etc.)
- ☐ Blood or bleeding disorders (low iron, easy bruising, etc.)
- ☐ Gastrointestinal issues (heartburn, constipation/diarrhea, etc.)
- ☐ Endocrine issues (diabètes, thyroid disease, etc.)
- ☐ Bone or muscle issues (osteoporosis, broken bones, muscle weakness)
- ☐ Neurological issues (seizures, migraines, head injury, stroke)
- ☐ Infection or immune issues (Lupus, sexually transmitted infections, etc.)
- ☐ Skin issues (acne, eczema, psoriasis etc.)
- ☐ Cancer (when, what type, treatment, active or in remission)
- ☐ Liver or kidney issues (cirrhosis, fatty liver, kidney failure, etc.)
- ☐ Hearing or vision issues
- ☐ Chronic pain (where, why)
- ☐ Other physical health issues not listed above:

Medications: On the next page, please list any medications you take **DAILY** or **AS NEEDED**. Include prescriptions, vitamins, herbals, over the counter meds or supplements, inhalers, creams, etc. that you take/use for your health. Include doses and frequency.

Medication Name	Dose	Frequency	Reason

Do you have any allergies? _____

Height: _____ft ____in Approximately weight in pounds: _____

For Biological Females:

Are you currently pregnant? YES NO Unsure

If yes: weeks' gestation, due date, complications, prenatal care (including name and number of provider)

_____

Are you sexually active? YES NO

Are you using contraception? YES NO If so, what type? _____

Circle one if you are post: menopause hysterectomy tubal sterilization

Mental Health History

Are you currently receiving mental health treatment anywhere? YES NO

If yes: where, and what type (counseling, meds, case management), and why do you wish to seek care at our agency?

_____

Have you ever received mental health services in the past? YES NO

If yes: when, where, and what type (counseling, meds, case management)

_____

For what reason (depression, anxiety, etc.)? _____

At approximately what age did you first receive treatment for your mental health? _____

What diagnoses have you been told you have?

_____

Have you ever been in the hospital for your mental health? YES NO

If yes: When, where, for what reason? Was this in the last 90 days?

_____

Has any close relative (parents, siblings, aunts, uncles, grandparents) been diagnosed with mental illness? YES NO

If yes, please list whom and with what illness:

_____

Substance Use

Are you in recovery from substance abuse? YES NO

If yes, from what substance(s) and for how long? _____

In the last 30 days, have you used any of the below?

- ☐ Caffeine (coffee, soda, energy drinks, etc.)
- ☐ Alcohol
- ☐ Nicotine (cigarettes, vape, tobacco chew, etc.)
- ☐ Marijuana/CBD/Kratom, including medical marijuana:
- ☐ Illicit/street drugs (such as meth, cocaine, heroin, Ecstasy, etc.)
- ☐ Prescription medications not prescribed to you (pain pills, Adderall, Xanax, etc.)
- ☐ Other substances not listed _____

Legal History

Do you have a guardian, power of attorney, or payee? If so, please list name and phone number:

_____

Are you currently on probation or parole? If so, please list your PO's name and phone number:

_____

If you have any other information that may be helpful for your clinician to know before your visit, please provide below:

_____