Patient Health History

Patient Name:___________________________________ **Date:**______________**Time:**__________________

Address:____

Home Telephone Number:______________________ **Cell Phone Number:**___________________________

Date of Birth:____________ **Age:**______ **Social Security Number:**__________________________________

Marital Status:______________ **How Many Times Have You Been Married:**_________________________

Current Partners Name:_____________________ **Partners Age:**______ **Phone Number:**_______________

Do You Have Children: Y / N If Yes Names and Ages:____

Who Is You Current Employer:___________________________ **Work Phone:**_______________________

Sexual Orientation:_____________________________ **Religion:**___________________________________

Have You Ever Been Involved in Therapy or Counseling: Y / N If Yes When:________________________

With Whom:________________ **Was Therapy Successful for You: Y/ N Explain:**____________________

Do You Currently Have Any Medical Conditions: Y / N Explain:__________________________________

Who is Your Current Medical Doctor and/or Psychiatrist:____

Have You Ever Been Hospitalized: Y / N Where and When:_______________________________________

____

Have You Ever Been to Rehab: Y / N Where and When:____

____

What Medications Are You Currently Taking:____

Do You Currently Use Drugs or Alcohol: Y / N What Type:_______________________________________

How Often Do You Use:____

When Did You First Begin Use of Each Substance:____

Do You Feel That You Use To Much or To Often: Y / N Why:___________________________________

Do You Have Any Current Legal Problems: Y / N Explain:_______________________________________

____

Have You Had Any Arrests or DUI's: Y / N Explain:____

Have You Ever Thought About Suicide: Y / N Explain:____

Have You ever Attempted Suicide: Y / N When and How:____

____

Have You Ever Been Diagnosed With A Psychiatric Disorder: Y / N When:_________________________

By Whom:________________________________ **Does Any Family Members Suffer From Either Psychiatric or Substance Related Disorders: Y / N Which Family Members:**________________________

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Briefly Explain Why You Are Here Today For Treatment:____

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____

What Do You Hope To Accomplish With Counseling:____

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Any Other Pertinent Information You Feel I Should Know About You or Your Situation:_____________

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Patient Signature: ____ **Date:**_________________________