Doreen A. Zaborac & Associates, Inc.

Zaborac Counseling Group

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Health History

Client/Patient Name (First & Last): _____ DOB: _____

HEIGHT: _____ WEIGHT: _____ SEX: _____ AGE: _____

WHAT ARE YOU SEEKING TREATMENT FOR? _____

_____

_____

HAVE YOU PREVIOUSLY RECEIVED PSYCHIATRY SERVICES? ▢ **YES** ▢ **NO**

PREVIOUS PSYCHIATRIST LAST VISIT DATE: _____

NAME: _____ LOCATION: _____ PHONE: _____

PRIMARY CARE PHYSICIAN LAST VISIT DATE: _____

NAME: _____ LOCATION: _____ PHONE: _____

PLEASE LIST ANY PREVIOUSLY DIAGNOSED MENTAL HEALTH CONDITIONS: _____

_____

_____

PLEASE LIST ANY MEDICAL CONDITIONS: _____

_____

_____

DO YOU HAVE A HISTORY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

▢ HEART PROBLEMS ▢ HIGH BLOOD PRESSURE ▢ LOW BLOOD PRESSURE

▢ DIABETES ▢ KIDNEY ISSUES ▢ LIVER ISSUES ▢ EPILEPSY

▢ OTHER ▢ NONE LIST OTHER:_____

_____

CLIENT/PATIENT NAME: _____

ARE YOU ALLERGIC TO ANYTHING? ▢ **YES** ▢ **NO**

IF YES, PLEASE LIST ALLERGIES: _____

_____

ARE YOU CURRENTLY OR COULD YOU BE PREGNANT? ▢ **YES** ▢ **NO**

ARE YOU CURRENTLY TAKING MEDICATION? ▢ **YES** ▢ **NO**

IF YES, PLEASE LIST **ALL** CURRENT MEDICATIONS: _____

_____

_____

PLEASE LIST ALL MEDICATIONS PREVIOUSLY PRESCRIBED FOR MENTAL HEALTH CONDITIONS: OR ▢ **N/A**

_____

_____

PLEASE DESCRIBE ANY NEGATIVE SIDE EFFECTS TO PREVIOUS MEDICATIONS: OR ▢ **N/A**

_____

_____

HAVE YOU BEEN PREVIOUSLY HOSPITALIZED FOR A MENTAL HEALTH CONDITION? ▢ **YES** ▢ **NO**

IF YES, PLEASE PROVIDE DATES, LOCATION, AND THE REASON FOR HOSPITALIZATION: _____

_____

_____

DO YOU HAVE A HISTORY OF SUICIDAL THOUGHTS OR ATTEMPTS? ▢ **YES** ▢ **NO**

IF YES, PLEASE PROVIDE DATES AND DESCRIPTION: _____

_____

_____

IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING: (CHECK ALL THAT APPLY)

▢ DEPRESSION ▢ BIPOLAR ▢ ANXIETY ▢ SCHIZOPHRENIA ▢ ADHD

▢ ADDICTION ▢ PERSONALITY DISORDERS ▢ SUICIDE ▢ OBSESSIVE COMPULSIVE DISORDER

▢ HEART PROBLEMS ▢ DIABETES ▢ HIGH/LOW BLOOD PRESSURE ▢ EPILEPSY

▢ LIVER DISEASE ▢ KIDNEY DISEASE

CLIENT/PATIENT NAME: _____

PLEASE CHECK ALL SYMPTOMS EXPERIENCED WITHIN THE LAST 6 MONTHS:

▢ EXCESSIVE WORRY/NERVOUSNESS ▢ PANIC ▢ PHOBIAS ▢ HEART PALPITATIONS

▢ FEELING ON EDGE ▢ AGITATION ▢ FEELINGS OF SADNESS ▢ TEARFULNESS

▢ SUICIDAL IDEATION ▢ ANGER/AGGRESSION ▢ LACK OF MOTIVATION ▢ SELF HARM

▢ OVEREATING/BINGING ▢ LACK OF APPETITE ▢ RESTRICTING FOOD ▢ PARANOIA

▢ DISINTEREST IN HOBBIES ▢ SUICIDE ATTEMPTS ▢ DIFFICULTY FOCUSING

▢ IMPULSIVITY/RECKLESSNESS ▢ HALLUCINATIONS ▢ EXCESSIVE SLEEP

▢ LACK OF SLEEP ▢ RESTLESSNESS ▢ EXTREME MOOD FLUCTUATIONS ▢ DELUSIONS

▢ WITHDRAWAL FROM FRIENDS/HOBBIES ▢ DRUG ABUSE ▢ ALCOHOL ABUSE ▢ ADDICTION

▢ EMOTIONAL OUTBURSTS ▢ BEHAVIORAL ISSUES ▢ PROPERTY DAMAGE ▢ VIOLENCE

▢ PHOBIA ▢ LOW SELF ESTEEM ▢ MEMORY ISSUES ▢ ACADEMIC ISSUES ▢ HEADACHES

▢ NEGLECTING PERSONAL HYGIENE ▢ MUSCLE TENSION/SORENESS ▢ DIGESTIVE ISSUES

▢ DIFFICULTY IN SOCIAL SITUATIONS ▢ RELATIONSHIP ISSUES ▢ RITUALIZED BEHAVIOR

▢ NONE ▢ OTHER: _____

PLEASE LIST YOUR TOP 3 SYMPTOMS AND INDICATE SEVERITY:

1. _____ ▢ **MILD** ▢ **MODERATE** ▢ **SEVERE**
2. _____ ▢ **MILD** ▢ **MODERATE** ▢ **SEVERE**
3. _____ ▢ **MILD** ▢ **MODERATE** ▢ **SEVERE**

DO YOU HAVE ANY CURRENT SUICIDAL THOUGHTS? ▢ YES ▢ NO
(IF YOU FEEL THAT YOU ARE A DANGER TO YOURSELF, GO TO YOUR NEAREST EMERGENCY ROOM.)

INDICATE STRESSORS EXPERIENCED IN THE PAST YEAR: (CHECK ALL THAT APPLY)

▢ ILLNESS ▢ FAMILY ISSUES ▢ DIVORCE/SEPARATION ▢ DEATH OF LOVED ONE

▢ LOSS OF RELATIONSHIP ▢ JOB CHANGE ▢ JOB LOSS ▢ FINANCIAL

▢ HOUSING ▢ RELATIONSHIP CONFLICT ▢ WORK ▢ EDUCATION ▢ PARENTING

▢ PREGNANCY ▢ CHILDBIRTH ▢ INCARCERATION ▢ LEGAL ISSUES

▢ MAJOR LIFE TRANSITION ▢ CHANGE IN RESIDENCE ▢ CHANGE IN SCHOOL

▢ LOSS OF PREGNANCY ▢ ESTRANGEMENT FROM CHILDREN ▢ VICTIM OF CRIME

▢ VICTIM OF RACISM ▢ NONE ▢ OTHER: _____

CLIENT/PATIENT NAME: _____

FAMILY & LIFESTYLE

▢ SINGLE ▢ MARRIED ▢ SEPARATED ▢ DIVORCED ▢ WIDOWED ▢ COMMITTED RELATIONSHIP

PLEASE PROVIDE INFORMATION ABOUT CURRENT OR PREVIOUS RELATIONSHIP IF APPLICABLE:

_____

_____

EMPLOYMENT: ▢ FULL TIME ▢ PART TIME ▢ UNEMPLOYED ▢ RETIRED ▢ HOMEMAKER

WHERE: _____ **POSITION:**_____

LENGTH OF EMPLOYMENT: _____

SATISFACTION: ▢ LOVE IT ▢ IT'S JUST A JOB ▢ DEPENDS ON THE DAY ▢ HATE IT

EDUCATION: ARE YOU A STUDENT? ▢ **YES** ▢ **NO CURRENT OR LAST GRADE COMPLETED:**_____

CURRENT/LAST SCHOOL: _____ **MAJOR:** _____

SATISFACTION: ▢ LOVE IT ▢ IT'S JUST OKAY ▢ DEPENDS ON THE DAY ▢ HATE IT

GRADES: ▢ **A** ▢ **A-B** ▢ **B-C** ▢ **C-D** ▢ **D-F**

ATTENDANCE: ▢ PERFECT ATTENDANCE ▢ MISS A COUPLE DAYS PER YEAR

▢ MISS A COUPLE DAYS PER SEMESTER ▢ MISS ONCE PER MONTH ▢ MISS OFTEN

SOCIAL: ▢ VERY SOCIAL/LARGE SOCIAL GROUP ▢ MODERATE/SOME FRIENDS ▢ NONE

PLEASE LIST ANY ACTIVITIES/CLUBS/EXTRACURRICULARS: _____

_____

PLEASE LIST ANY HOBBIES OR INTERESTS:_____

_____

PLEASE LIST THE NAMES, AGES AND RELATIONSHIPS OF THE PEOPLE LIVING IN YOUR HOME:

_____

_____

WHAT ELSE WOULD YOU LIKE US TO KNOW ABOUT YOU?

_____

CLIENT/PATIENT NAME: _____

_____