# Confidential Health Assessment Form for Adults

Client Name:_____ DOB_____ Date:_____

(OR) Name of person completing this form:_____
Relationship to Client

***Please check all of the items that apply, currently or in the past:***

| | | |
|---|---|---|
| ____ Anemia | ____ Fainting | ____ Pneumonia |
| ____ Arthritis | ____ Fever (unknown origin) | ____ Rashes |
| ____ Asthma | ____ Headaches-Chronic | ____ Sexual difficulty |
| ____ Bleeding Disorder | ____ Hearing Impairment | ____ Sexually Transmitted Disease |
| ____ Cancer | ____ Heart Problem | ____ Thyroid Problem |
| ____ Diarrhea-Chronic | ____ High Blood Pressure | ____ Tuberculosis |
| ____ Diabetes | ____ HIV illness | ____ Ulcer |
| ____ Dizziness | ____ Liver problem | ____ Low Blood Pressure |
| ____ Seizures | ____ Weight Gain or Loss | ____ Eye Problem |
| ____ Nausea | ____ Fatigue | ____ High Cholesterol |
| ____ Irritable Bowel | ____ Chronic Pain | ____ Depression or Anxiety |
| ____ Infertility (in self or partner) | | ____ Menstruation or Menopause Difficulties |

____ Problems with Pregnancies: (e.g. abortion, miscarriage)_____
**___ Any Allergies (food, animals, medicines or other substances):_____**
____ Other/Surgeries:_____

***Please identify the doctor or clinic treating you currently for the above items:***

**Problem** **Physician or Medical Facility**

_____

_____

_____

***Please list any medical or mental hospitalizations you have had in the last five years:***

**Dates of Hospitalization** **Where Hospitalized** **Reason**

_____

_____

***Please list all medications you are currently taking: (If needed, add additional on page 2)***

**Medication Dosage Frequency Condition being Treated Prescribing Physician**

_____

_____

_____

***How often have you have used any of the following substances in the last six months:***

***Key:***

**5=Daily 4=4-5 times/week 3=1-3 times/week 2=more than once/month 1=less than once/month 0=never**

| | | |
|---|---|---|
| ____ Xanax/Klonopin/Ativan | ____ Huffing | ____ Ecstasy |
| ____ Cigars/Chewing Tobacco | ____ Pain Killers | ____ Heroine or Methadone |
| ____ Alcohol | ____ Codeine | ____ LSD, PCP or Mushrooms |
| ____ Sleeping Pills | ____ Marijuana/Hash | ____ Amphetamines (Speed/Uppers) |
| ____ Laxatives | ____ Cocaine/Crack | ____ Nicorette Gum/Lozenge _____ |

____ Cigarettes (How many/packs a day?)_____
____ Caffeine (How many cups/ounces/cans-specify?) _____

Other_____

***Turn Page Over & Complete Other Side>>***

***Have you ever been treated for drug or alcohol problems?*** ___*Yes* ___*No*

*If yes, when and where?*_____

*Have you ever attended AA, NA or Al-Anon? ___Yes ___No*

1. *Has anyone ever expressed any concern about your use of drugs or alcohol? ___Yes___No*

2. *Have people annoyed you by criticizing your drinking or drug use? ____Yes ____No*

3. *Have you felt bad or guilty about your drinking or drug use? ___Yes ____No*

4. *Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ___Yes ___No*

*Have you ever had a DUI? ___Yes ___No If yes, when and where?*

_____

*Have you ever had an alcohol or drug-related arrest? ___Yes ___No If yes, what was the charge?*

_____

*Have you ever been court-ordered to attend an Alcohol Diversion Program? ___Yes ___No*

*If yes, when and where?*_____

***Nearly everyone has, at some time, felt discouraged. Please circle the number that best describes how you feel right now:***

*0. I am not particularly discouraged about the future.*
*1. I feel discouraged about the future.*
*2. I feel that I have nothing to look forward to.*
*3. I feel that the future is hopeless and that things cannot improve.*

***Many people have had thoughts about ending their lives. Please circle the number that best describes how you feel right now:***

*0. I don't have thoughts about killing myself.*
*1. I have thoughts about killing myself but would not carry them out.*
*2. I would like to kill myself.*
*3. I would kill myself if I had the chance.*

***Have you ever tried to kill yourself?***

*0. Never*
*1. Self-Mutilation*
*2. At least one attempt*
*3. More than one attempt*

Would you like to sign a release allowing your therapist and your physician (PCP) to communicate about your concerns and/or medications? ___Yes, ___No, or ___ *I'd like to discuss this with my therapist.*

**How did you hear about us? Please check all that apply**: ☐ Insurance/Managed Care referral
☐ Internet search ☐ Phone Book ☐ Physician's Office ☐ Friend/Family ☐ Our website
☐ Professional Referral's Name (e.g. therapist, attorney, pastor): _____
☐ Other: _____

***Please note below anything else you think would be helpful for us to know about your health, or any medications you did not have room for on page 1. Thank you!***

_____
_____
_____
_____
_____