gateways counseling & consulting center
care • compassion • competence

Health Information:

Your name: _____ Date of birth: _____ Age: _____

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, and any other medical conditions you have had._____

_____

2. Describe any allergies you have. _____

3. List *all* medications, drugs, or other substances you take or have taken in the last year – prescribed, over-the-counter vitamins, herbs, and others.

_____

_____

4. Have you done any kinds of work where you were exposed to toxic chemicals? Explain:

_____

5. What kinds of physical exercise do you get?

_____

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

_____

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

_____

8. Do you have any problems getting enough sleep?

_____

9. Are there any other medical or physical problems you are concerned about?

_____

Chemical use:

1. Have you ever felt the need to cut down on your drinking? Yes / No
2. Have you ever felt annoyed by criticism of your drinking? Yes / No
3. Have you ever felt guilty about your drinking? Yes / No

4. Have you ever taken a morning “eye-opener”? Yes / No

5. How much beer, wine, or hard liquor do you consume each week, on the average?

_____

6. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? Yes / No

7. How much tobacco do you smoke or chew each week? _____

8. Have you ever used inhalants (“huffing”), such as glue gasoline, or paint thinner? Yes / No
If yes, which and when?

9. Which drugs (not medications prescribed to you) have you used in the last 10 years? Please provide details about your use of these drugs or other chemicals, such as amounts and how often you used them.

_____

_____

Additional Information:

1. Do you consider yourself to be spiritual or religious? Yes / No If yes, describe your faith or belief. _____

2. What do you consider to be some of your strengths?

_____

_____

3. What would you like to accomplish out of your time in therapy?

_____

_____

4. Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes / No
If yes, when did you begin experiencing this? _____

5. Are you currently experiencing any chronic pain? Yes / No
If yes, please describe. _____

6. Are you currently in a romantic relationship? Yes / No
If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

7. What significant life changes or stressful events have you experienced recently?

_____

_____

Family Mental Health History:

	Circle one	List Family Member
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disorders	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Behavior	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	