CareNet Counseling East

Health Information

Name: _____ CHART# _____

PLEASE CIRCLE THE APPROPRIATE ANSWER OR FILL IN THE BLANK:

Do you have periods of feeling sad, blue, depressed?	YES NO	_____
Do you have any problems with sleeping?	YES NO	_____
Has your appetite changed recently?	YES NO	_____
Have you gained or lost weight recently?	YES NO	_____
Do you have much fun these days?	YES NO	_____
Do you feel tired all the time?	YES NO	_____
Can you concentrate on things as well as you have in the past?	YES NO	_____
Is your sex drive lower than it has been in the past?	YES NO	_____
Do you have crying spells?	YES NO	_____
Do you think about hurting or killing yourself or anyone else?	YES NO	_____
Do you feel good about yourself?	YES NO	_____
Do you feel anxious, nervous, or stressed much of the time?	YES NO	_____
Have you ever been so nervous that you had trouble breathing?	YES NO	_____
Are you deathly afraid of anything?	YES NO	_____
Do you have any thoughts that get in the way of your doing things you want to do?	YES NO	_____
Is there anything that you do (for example: checking locks, washing hands, cleaning things, a lot more than other people?	YES NO	_____
Do you worry all the time?	YES NO	_____
Are there times when your mind races and you feel out of control?	YES NO	_____
Do you smoke?	YES NO	_____
Do you drink alcohol?	YES NO	_____
Do you use recreational drugs?	YES NO	_____
Have you ever had a DUI?	YES NO	_____
Has a doctor ever advised you to stop smoking, drinking or using drugs?	YES NO	_____
Have you lost work because of drinking or using drugs?	YES NO	_____
Does your family complain about your drinking, smoking or using drugs?	YES NO	_____

Name: _____ CHART#_____

Has anyone in your family

had nervous problems?	YES	NO	_____
been depressed?	YES	NO	_____
taken medication for nerves or depression?	YES	NO	_____
attempted or committed suicide?	YES	NO	_____
been in a psychiatric hospital?	YES	NO	_____
drunk too much?	YES	NO	_____
used drugs?	YES	NO	_____
been in jail?	YES	NO	_____

Did you experience excessive physical punishment as a child?	YES	NO	_____
Have you ever been a victim of severe and unexpected violence?	YES	NO	_____
Did you lose a parent through death during childhood?	YES	NO	_____
Do you consider yourself a religious person?	YES	NO	_____
If married, are you satisfied with your relationship?	YES	NO	_____
Are there sexual matters you would like to discuss?	YES	NO	_____
If employed, do you like your job?	YES	NO	_____
If you have children, what are their ages?			_____
Is your health good?	YES	NO	_____
Have you been sick lately?	YES	NO	_____

Please circle if you have:

headaches	sweating	shortness of breath	dizziness
couch	backache	pins and needles	diarrhea
seizures	palpitations	bowel problems	vomiting
stomach ache	other _____		

Date of your last physical? _____

Name of your doctor? _____

Address _____

List any health problems you have:

_____

_____