Healing & Refuge Centre', LLC
E. LaMonica Williams, MSW, LSCSW
250. N. Rock Rd. Suite 300F
Wichita, Ks

HEALTH HISTORY/CLIENT INTAKE FORM

Name_____

Allergies: _____ _____

Psychiatrist or treating Dr.: _____

Current Medications:
Med. _____ Dose (mg) _____ Times/day_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Include any other medications on the back of this sheet:
Do you currently use any of the following?

Caffeine:
Coffee amount/day: _____ Tea amount/day:_____ Soft drinks: amount/day_____

Alcohol:
Beer: amount_____ per (circle one) day, week, month
Mixed drinks/neat (amount in ounces of alcohol) _____ per day, week, month

Drugs:
Marijuana amount _____ per (circle one) day, week, month

Stimulants:
Cocaine, Methamphetamine, etc. amount_____ per day, week, month

Other drugs: List type, frequency, and amount _____
_____

Have you ever received treatment for addictions? When/Where _____

Cigarettes, cigars, chew tobacco, snuff amount _____ per day, week, month,

Head injuries:

Falls, accidents where you hit your head: explain _____
Concussions, closed head injuries, head injuries: _____

Did you ever play football_____ other contact sport _____
Have you ever lost consciousness? Explain _____

Used any inhalants, exposed to toxic materials _____

Hospitalizations/surgeries:

Age: _____ Reason _____

Age_____ Reason _____

Check any of the below symptoms if you have had them within the last 6 months:

_____ Headaches, neck pain
_____ Back pain
_____ Shortness of breath/pressure in chest
_____ Pounding heart/fluttering
_____ Recent gain/loss of weight
_____ Indigestion/bowel problems
_____ Epilepsy/seizures
_____ Vision problems
_____ Memory loss/ increased forgetfulness
_____ Eating problems (restricting, overeating)
_____ Anxiety attacks/nervousness
_____ Fatigue/more tired
_____ Skin problems
_____ OB/GYN problems
_____ Worrying/obsessing
_____ Phobias, fears
_____ Anger/rages

Sleep problems, describe _____

Other physical problems that you are concerned about: _____

Trauma: Have you experienced any of the following?
Sexual abuse, assault (ages) _____

Physical abuse, domestic violence, assault (ages)_____

Accidents, incidents that were traumatic _____

Have you ever witnessed a traumatic event? _____

Do you have any of the following? Please check.
____ Diabetes
____ Heart problems: list_____
____ Asthma
____ Bipolar
____ Depression
____ Thyroid: list_____

____ Addictions: List_____

____ Learning disabilities _____