Beach Counseling Center LLC

History

Name: _____ Date:_____

Age: _____ Sex: _____ Date of Birth: _____

Marital Status: ___Single ___Married ___Widowed ___Separated ___Divorced ___Unmarried Couple

What is the reason for your visit today? _____

_____

MEDICAL HISTORY:

Name of Family Physician:_____ Phone # _____

Height: _____Weight: _____Date of last visit: _____

Allergies food/medication: _____

_____

Do you have any of the following: Check all that apply

___ Heart Palpitations ___ Seizures ___ Head Injury ___ Muscle pain/weakness

___ Chest Pains ___ Fainting Spells ___ Migraines ___ Blood pressure low/high

___ Shortness of Breath/Asthma ___ Black outs ___ Epilepsy

Sleeping Habits: ___Difficulty Falling Asleep ___Insomnia ___Restless ___Early morning waking ___Nightmares

Do you have or have you had any eating disorders? ___ Yes ___No

Do you smoke cigarettes? ___Yes ___ No If yes, how much per day? _____

Do you drink alcohol? ___Yes ___ No If yes, how much per day? _____

Illegal Drug Use? ___Yes ___ No If yes, how often? _____

Medications:

Medication	Dose	Reason

Psychiatric History

Do you have any of the following or had in the past? Had a diagnosis of:

___ Depression ___ Anxiety ___ Trauma ___ schizophrenia ___ Bipolar Disorder ___Panic Attacks

___ Postpartum Depression ___Anorexia ___ Binge Eating Disorder___ Bulimia

___ Autism ___Attention Deficit Disorder ___ Obsessive-Compulsive Disorder

Is there a family history of Mental Illness: ___ Yes ___ No If yes, please explain_____

_____

Have you ever been admitted as an inpatient for psychiatric purposes? ___Yes ___ No If yes, please explain.

_____

_____

_____

Former Psychiatrist and Therapist (Please list names and telephone numbers)

_____

_____

Other History

EDUCATIONAL HISTORY: Indicate your highest level of education:

___Grade School	_____ Number of years completed
___High School	_____ Number of years completed
___College	_____ Number of years completed
___Advanced Degree	Area of study: _____

JOB PERFORMANCE:

Has your employer or supervisor every expressed any of the following concerns to you? (check all that apply)

___ Missing too much work	___ Assigned tasks not completed	___ Irresponsibility
___ Poor/bad attitude	___ Difficulty getting along with others	___ Late too often
___ Attitude/behavior change	___Difficulty getting along with supervisors	___ Increasing errors

MILITARY HISTORY:

Have you ever served in the military service? ___ Yes ___ No

Did you ever serve in combat? ___ Yes ___ No

LEGAL HISTORY:

Do you have any legal action now pending? ___ Yes ___ No If yes, please explain:_____

_____

Are you currently on probation and or parole? ___ Yes ___ No

If yes, please describe: _____

LEISURE RECREATIONAL INTEREST & HOBBIES:

Would you consider your life as:

Work Oriented	___ Yes ___ No	Family Oriented	___ Yes ___ No
Self Oriented	___ Yes ___ No	People Oriented	___ Yes ___ No

_____

Do you exercise on a regular basis? ___ Yes ___ No ___ 1-2 times weekly ___ 3-4 times weekly

Do you have physical limitations that prevent exercise or physical activity: ___ Yes ___ No

If yes, please describe: _____