Behavioral Health Record

Please complete as much of this form as you can. Bring the form to your first session.
This information is vital to the treatment process.

Name: ___________________________________ Age: ___ DOB: _______ Gender: __________

Address: ____

Home Phone #: _____________________________Cell Phone#:___________________________

Referred by: ______________________ Emergency Contact Name: ________________________

Relationship to emergency contact: _____________________Phone: (____) _________________

Is there a phone number where your therapist can leave you a detailed message? □ yes □ no
If yes, what is the number? ____

Present concerns
What has led you to seek help at this time? ____
____
____

Have you already tried to resolve these concerns? If so, what did you do and how did it work?
____
____
____

Who do you go to for support (family, friends, faith or spirituality, support or self-help groups)?
____
____

What strengths or resources do you have that will help you succeed in counseling? (Examples include commitment, strong family support, intelligence, good social support, church, friends, etc.)____
____
____

What might prevent your success in counseling? (Examples include few friends, financial stress, lack of social support, lack of family support, etc.)_____________________________________
____
____

Social History

Please check the item that best describes you below:
 Single Married Remarried Partner or significant other
 Separated Divorced Widowed Other ________________________

Please describe your living situation. Check all that apply:
 With spouse With partner or significant other With children With parents
 Alone With roommate Other________________________

Please tell us if you are working. Check all that apply:
 Employed Unemployed Full-time parent Volunteer or other
If you work outside the home (in a paying job or as a volunteer), describe the job and how long you have held it: ____
Name/Address of Employer____

Which of the following best describes you? (Optional)
 African African American Asia Hawaiian or Pacific Islander
 Latino/Latina Native American Bi-racial White None of the above

Ethnicity, culture and religion

Please share any ethnic, cultural or religious concerns that may be helpful to your therapist:
____
Is English your preferred language? yes no
If no, list language:
____
Would you like an interpreter or other support involved in your therapy? yes no

Legal status

Have you ever been involved with the legal system (child custody, order for protection, DWI, etc.)? yes no
If yes, please describe: ____
____

Education

Please list the highest grade you have completed: _____________________________________
Do you have learning problems in any of these areas? Speech Hearing Reading
 Writing Concentration Attention Other: _______________ None

If you have problem areas or a preferred way to learn, please describe:
____
Tell us about your childhood:
Where did you grow up? ____

Were your parents always married, or was there a divorce? ________________________
If they divorced, how old were you at the time? ________________________________
How many siblings do you have? __________What was your birth order? ____________
How would you describe your childhood? _____________________________________
____
____

Tell us about your current family. Please list the members of your family and household below.

Name	Age	Relationship	Living in same house?(circle)
			Yes No
			Yes No
			Yes No
			Yes No

How would you describe relationships in your current family? ___________________________
____
____

Tell us about any other marriages or committed relationships you have had.
Length of relationships: ____
Do you have children from other relationships? ☐ yes ☐ no
If yes, give names and ages (unless already named above): ________________________

Mental health and chemical dependency in your family of origin

Please list any relatives (blood relatives) who have had mental health issues.
Depression: ____
____
Bipolar/manic depression: ____
____
Anxiety (panic attacks, obsessive-compulsive disorder, phobias): __________________
____
Schizophrenia: ____
____
Suicide: ____
____
Eating disorder: ____
____
Attention deficit disorder: ____
____
Drug or alcohol abuse or dependency: ______________________________________
____

Your mental health and chemical dependency history

Have you ever had therapy, counseling, hospital treatment or medicines for:

Mental health problems? ☐ yes ☐ no Chemical dependency? ☐ yes no

If yes, when, where and what was being treated?

Date	Treated For	Treatment Type (*hospital,medicine,counseling*)	Provider or Location of care

<u>Please complete the following.</u>

1. In the past year, have you felt you ought to cut down on your drinking or drug use? ☐ yes ☐ no

2. In the past year, have you had people annoy you by criticizing your drinking or drug use? ☐ yes ☐ no

3. In the past year, have you felt bad or guilty about your drinking or drug use? ☐ yes ☐ no

4. In the past year, have you had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves, to get rid of a hangover or to get the day started? ☐ yes ☐ no

Please describe your current use of the following.

Yes No

☐ ☐ **Alcohol ______** times per day / week / month / year (circle one).
How much at a time? ______________ When did you first start using it? _______________

☐ ☐ **Tobacco______** times per day / week / month / year (circle one).
How much at a time? ______________ When did you first start using it? _______________

☐ ☐ **Caffeine ______** times per day / week / month / year (circle one).
How much at a time? ______________ When did you first start using it? _______________

☐ ☐ **Marijuana ______** times per day / week / month / year (circle one).
How much at a time? ______________ When did you first start using it? _______________

☐ ☐ **Other**: ________________________ times per day / week / month / year (circle one).
How much at a time? ______________ When did you first start using it? _______________

☐ ☐ **Use of prescription or over-the-counter medicines ______** times
per day / week / month / year (circle one). How much at a time? ______________
When did you first start using it? _______________

List any problems you have had because of drinking or drug use (with friends, the law, your money, your job, sex, school, family): ____
____

Trauma and abuse history

Describe any major losses you have had (such as death, disability, divorce, relationship changes):
____
____
____

Describe any trauma or abuse in your life (such as physical, sexual or emotional abuse; assault; neglect; domestic violence; witnessing the abuse of another, etc.):

Physical abuse: ____
Sexual abuse: ____
Emotional abuse: ____
Neglect: ____
Assault: ____
Military-related trauma or distress: ____
Discrimination: ____
Other: ____

Safety concerns

Have you ever thought about hurting or killing yourself, or had an impulse to do so? □ yes □ no
If yes, do you have a suicide plan? □ yes □ no
If so, please explain: ____
____

Have you ever tried to hurt or kill yourself? □ yes □ no
If yes, list the date and method: ____
____

Have you ever harmed property or other people, or thought about causing harm? □ yes □ no
If yes, please explain: ____
____

To your knowledge, are there firearms in your home? □ yes □ no
If known, how many and of what type (pistol, revolver, rifle, automatic)? _____________
____
Do children or teens have access to these firearms? □ yes □ no
Are these firearms stored unloaded and locked with trigger guards? □ yes □ no
(You can get trigger guards free of charge from the local police departments)
Is the ammunition (bullets) kept in a separate location? □ yes □ no

Medical status (attach another page, if needed)

Do you have a primary care clinic or doctor? □ yes □ no

Name of clinic or doctor ____

Phone (___) ______________________________Fax (___) ________________________

Have you had a physical exam to check for medical reasons for your symptoms? □ yes □ no

Date of your last physical exam _____________________________________

Do you have a psychiatrist? □ yes □ no

Name of psychiatrist____

Phone (___) _____________ Fax (___)____________ Date of last visit: ______________

Have you ever had any major-medical problems? □ yes □ no

If yes, please explain: ____

____

____

Do you currently have any physical pain? □ yes □ no

If yes, please explain: ____

____

Are you concerned about your weight or eating habits? □ yes □ no

Are other people concerned? □ yes □ no

If yes to either question, please explain: ____

____

Are you taking any medicine (prescribed or over-the counter) or Herbal products? □ yes □ no

If yes, please list these below.

	Example	Medicine #1	Medicine #2	Medicine #3	Medicine #4	Medicine #5	Medicine #6
Name of Medicine	*Celexa*						
How many milligrams (mg)?	*40mg*						
How many pills do you take at a time?	*one*						
How many times a day do you take this medicine	*once*						
What time of day do your take this medicine?	*morning*						
What does this medicine treat?	*depression*						
Name of prescribing doctor	*Dr. Jones*						

IF YOU NEED MORE SPACE, PLEASE ATTACH ANOTHER SHEET OF PAPER.

Medical status (continued)

Do you have any allergies? ☐ yes ☐ no

Have you ever had a bad reaction to medicine? ☐ yes ☐ no

If yes to either question, please describe: ____

____

Please check off and explain any symptoms you are having

Symptoms or stressors	When did it start?	How often does it happen?	Therapist notes *(mild, moderate, or severe)*
☐ Compulsive behaviors *(too much hand washing, checking, TV, spending)*			
☐ Grief *(job loss, death, health)*			
☐ Relationship problems			
☐ Sexual issues *(orientation, identity, function)*			
☐ Financial issues			
☐ Racing thoughts			
☐ Trouble making decisions			
☐ Impulsive behavior			
☐ Nightmares			
☐ Muscle tension or headaches			
☐ Feeling shaky			

Any additional information you would like to provide:

____

____

____

____

____

________________________________ *for office use only* ________________________________

Intake Date: ____________________ Dx: ____

Reviewed by: ______________________________________ Date: ______________________

(Therapist signature and credentials)

Discharge Date: __________________ Dx: _______________________________________

Reviewed by: ______________________________________ Date______________________

(Therapist signature and credentials)