

HYGEIA COUNSELING SERVICES

MEDICAID VERSION

Proper treatment requires as much historical information as possible. Please fill this out to the best of your abilities. Completing this outside of session will maximize our therapy time. We will likely go over some of the answers. Please feel free to ask questions or to write "I decline" for information you would rather not reveal.

Name: _____ Date of Birth: _____

Past Psychiatric Information

Prior Counselor/Psychiatrist _____		Prior Counselor/Psychiatrist _____
Dates of Treatment _____		Dates of Treatment _____
Treated for: _____		Treated for: _____
Type of Treatment (circle one) outpatient inpatient group medication other _____		Type of Treatment (circle one) outpatient inpatient group medication other _____

Have you ever been hospitalized for **mental health** concerns, enrolled in a group home, a psychiatric rehabilitation program (PRP), or a day hospital/intensive outpatient program (IOP)? If so -- please list facility information, reason, and dates as best you can remember.

When did the above psychiatric concerns first start?

What symptoms and behaviors did you experience as part of the above psychiatric concerns?

Has anyone in your family ever been diagnosed with or thought to have symptoms of any mental disorder? If so, whom and what illness? Any suicide attempts by family members?

Current Psychiatric Information

What are you coming to see me for? (What is your presenting concern?)

Why are you coming now? (What are the circumstances leading to us talking?)

When did your current concern start?

Please continue psychiatric information on the back of the page as needed.

Medical History

Please circle if you currently have: Asthma/COPD | Cancer | Cardiovascular Disease | Chronic Pain | Dementia | Diabetes | Obesity

Please list any other past and present major medical conditions:

Please list past and present medical conditions that you believe have had an impact on your mental health:

Psychosocial History

Marital Status (circle one): married domestic-partner divorced separated single

Children's names & ages (if any): _____

Please list people who are emotionally supportive of you: _____

Do you have a history of interaction with the law? If so, what: _____

Highest degree you have achieved (circle one): high-school 2-yr-college 4-yr-college masters doctorate other

What are your hobbies, interests, & daily activities?: _____

Name & age of parents (if deceased, cause & age at death): _____

Nature of relationship with parents (past & current): _____

Sibling's names & ages (if any): _____

Work History

Please list last four job titles & dates held:

What are your career goals?

How satisfied are you with current job (if employed)?

Medication/Drug History

Names, dosage, & notable side effects of current medication:

Past psychiatric medications (including ADHD, sleep, & anti-depressants from somatic physician):

Frequency and quantity of caffeinated beverages, nicotine products, alcohol, illegal drugs, and marijuana:

Have you ever been hospitalized for **substance abuse** concerns? If so -- please list facility information, reason, and dates as best you can remember. Please list number of hospitalizations in past 12 months and in your life-time.

Please continue substance abuse information on the back of the page as needed.

Alcohol & Drug Use:

When thinking about drug use, include illegal drug use and the use of perscription drug use other than prescribed. Please circle YES or NO for each question.

1. Have you ever felt that you ought to cut down on your drinking or drug use? | YES / NO
2. Have people annoyed you by criticizing your drinking or drug use? | YES / NO
3. Have you ever felt bad or guilty about your drinking or drug use? | YES / NO
4. Have you ever had a drink or used drugs first thing in the morning to steady your | YES / NO
nerves or get rid of a hangover?

Special Factors

Are you currently suicidal or homicidal? _____

Do you have a history of either one? _____

Are you court-ordered or otherwise required to receive treatment? _____

Do you have a history of self-mutilation such as cutting or burning yourself? _____

Have you ever been diagnosed with, or thought to have, anorexia or bulimia? _____

Do you have weapons in your home? _____

Have you ever been abused? (circle one) no sexual rape physical domestic-violence What age? _____