

AFFILIATES IN BEHAVIORAL HEALTH, LLC® HEALTH AND WELLNESS HISTORY

Name		Date	
Parent or Guardian		DOB	PCP
MENTAL HEALTH TREATMENT		DETAILS	
Why are you seeking treatment today?			
What has made this an issue <i>now</i> ?			
Ever had treatment in the past? For same problem? Who treated you?			
What type of treatment was that (outpatient, inpatient, IOP, PH, medication, ECT)?			
Are you currently in treatment now? If yes, with who?			
What type(s) of treatment (outpatient, inpatient, IOP, PH, medication, ECT)?			
What has helped you to feel better in the past?			
HOW MUCH OF THE FOLLOWING DOES THE PATIENT CONSUMES DAILY?			
ALCOHOL		CIGARETTES	
CANNABIS/MARIJUANA		LAXATIVES	
SLEEPING PILLS		HERBAL REMEDIES	
WATER PILLS		IPECAC	
DIET PILLS		OTHER	
PLEASE CHECK (✓) THE AREAS AFFECTED BY YOUR PROBLEM(S).			
FAMILY RELATIONSHIPS		EATING OR WEIGHT	
FRIENDS AND OTHERS		SLEEPING AND ENERGY	
JOB OR SCHOOL		SEXUAL FUNCTIONING (IF RELEVANT)	
LIFE TRANSITION		CONCENTRATION AND MEMORY	
FINANCIAL		ANGER MANAGEMENT	
MEDICAL PROBLEMS		LEGAL PROBLEMS	
ANXIETY OR NERVES		FAITH AND SPIRITUALITY	
PLEASE LIST <u>ALL</u> OF YOUR CURRENT MEDICATIONS ALLERGIES:		PLEASE CHECK (✓) ANY PROBLEMS THAT YOU HAVE NOW OR HAVE RECEIVED TREATMENT FOR IN THE PAST.	
<i>Rx</i>		ADDICTIONS	EATING DISORDER
<i>Rx</i>		ANEMIA	FERTILITY
<i>Rx</i>		ANXIETY OR STRESS	HYPERTENSION
<i>Rx</i>		BULIMIA	IRRITABLE BOWEL
<i>Rx</i>		CANCER	MULTIPLE SCLEROSIS
<i>Rx</i>		CARDIAC PROBLEMS	OBESITY
<i>Rx</i>		DEMENTIA	PARKINSON'S
<i>Rx</i>		DEPRESSION	SEIZURES/TREMORS
<i>Rx</i>		DIZZINESS	
<i>Rx</i>		DIABETES	
<i>Rx</i>		EPILEPSY	

ANYTHING ELSE YOU WOULD LIKE YOUR DOCTOR OR CLINICIAN OR DOCTOR TO KNOW OR ASK ABOUT?
