CLIENT BACKGROUND INFORMATION

Behavioral Health Centers are required by the State of Ohio and other authorities to request the following information from our clients. Please answer the following questions as completely as you can. The staff person you work with at your first appointment will review them with you and answer any questions you may have. This information will be kept confidential unless you provide written permission to share it or we are required to release it by a court of law.

Name: [ ] Mr [ ] Mrs [ ] Ms _____
First Name MI Last Name

Maiden Name: _____ Date of Birth: _____ Social Security Number: _____

Gender: [ ] Male [ ] Female Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ Zip: _____

Employment Status: __ Full-Time __ Part-Time __ Disabled __ Homemaker
__ Engaged in Residential/Hospitalization __ Inmate of Jail/Prison/Corrections __ Retired
__ Not in Labor Force __ Student __ Volunteer Worker __ Actively Looking for Work

Primary Source of Income/Support: __ Wages/Salary __ Family/Relative __ Public Assistance __ Disability
__ Retirement/Pension __ Other __ None

Who referred you to us? __ Self/Family/Friend __ AOD Care Provider __ Mental Health Provider
__ Other Health Care Provider __ School __ Employer/EAP __ Child Welfare (CSB, DJFS)
__ Community Referral __ Prison/Jail/Criminal Justice __ Ohio Families and Children First Council

Whom should we contact in case of emergency? Name: _____ Phone: _____
Relationship: _____ Address: _____

What is your marital status? __ Married/Partner __ Divorced __ Widowed __ Separated
__ Single

What are your living arrangements? __ Own Home __ Community Residence __ Crisis Care
__ Correctional Facility __ Foster Care __ Other's Home __ Residential __ Respite Care
__ State MH/MR Institution __ Temporary Housing

Racial or ethnic group? __ Caucasian __ African-American __ Other Single Race
__ Native Hawaiian/Pacific Islander __ Asian __ American Indian __ Two or More Races
Sexual Orientation: __ Heterosexual __ Homosexual __ Bisexual __ Pansexual
__ Asexual __ Demisexual __ Greysexual

Education: __ K-12th Grade __ GED Classes __ Not Enrolled __ Vocational/Job Training __ College
__ Other school: Adult Basic Ed., Literacy __ Behaviorally Handicapped __ Not Behaviorally Handicapped

What is the main language you speak? __ English __ Spanish __ Nepali
__ French __ Japanese __ Chinese __ German __ American Sign Language

Military Status: __ None __ Active __ Discharged __ Disabled Veteran

Military Service: __ Served in Iraq __ Served in Afghanistan __ Not Applicable

What is your citizenship status? __ a. US citizen __ b. Student VISA __ c. Other VISA __ d. None above

Please list children here:	Date of Birth	Lives with you?		Stepchild?	
Name_____	_____	[ ] Yes	[ ] No	[ ] Yes	[ ] No
Name_____	_____	[ ] Yes	[ ] No	[ ] Yes	[ ] No
Name_____	_____	[ ] Yes	[ ] No	[ ] Yes	[ ] No
Spouse/Partner _____	_____	[ ] Yes	[ ] No		

List additional people in your household:

How many cups of ***caffeine*** do you drink per day? [ ] None [ ] 1-3 [ ] 4 or more

Smoking status: __ Current smoker - every day __ Current smoker - some days __ Never smoked
__ Former smoker __ Smoker, current status unknown __ Unknown if ever smoked

Do you use any other kinds of tobacco products? __ Cigars __ Snuff __ Chewing Tobacco

Please list any hospitalizations you have had for ***emotional*** or ***mental health*** reasons:

Hospital	City	Date(s)	Reason	How Long?

List any other outpatient mental health care you are receiving or have received:

Counselor/Doctor	City	Date(s)	Reason	How Long?

Do you currently have any legal problems or active charges? __ None __ Charges Pending
__ On Parole/Probation

Describe: _____

Medications/Allergies

Do you have any allergies? __ Yes __ No Allergies to medications? __ Yes __ No

If you have any allergic reactions with your medications please describe them below:

_____

If you have ever been prescribed any medication for emotional or psychiatric support in the past, please list them below:

_____

Are you currently taking any medications? (prescribed or OTC) __ Yes __ No If yes, please list below:

Name	Dose	How often?	Reason?	Prescribed by?

Symptoms or Concerns

Please check any of the following which have been a problem or concern for you in the past 2-4 weeks:

[ ] sleeping - not enough	[ ] loss of pleasure	[ ] work/school conflict or stress	[ ] nightmares
[ ] sleeping - too much	[ ] loss of interest/apathetic	[ ] marital conflict or stress	[ ] guilt or shame
[ ] appetite or eating problems	[ ] poor self esteem/image	[ ] other relationship problems	[ ] grief or loss
[ ] weight loss or gain	[ ] stress or tension	[ ] thoughts about harming self	[ ] confusion
[ ] sadness, tearfulness	[ ] concentration problems	[ ] thoughts about harming others	[ ] loneliness
[ ] anxiety, nervousness	[ ] memory problems	[ ] other odd or troubling thoughts	[ ] legal problems
[ ] panicky or panic attacks	[ ] sexual problems	[ ] hearing voices/seeing things	[ ] not assertive enough
[ ] fearfulness or paranoia	[ ] court or DHS requires	[ ] alcohol or drug problems	[ ] physical health problems
[ ] anger, hurting others	[ ] housing problems	[ ] sexual abuse victim	[ ] physical abuse victim

Other: _____

Health History Questionnaire

Please check all medical conditions which currently apply or have previously applied.

__ problems with vision	__ headaches	__ blurriness	__ wear glasses	__ diabetes
__ problems with hearing	__ ringing in ears	__ wear hearing aid	__ difficulty walking	__ problems with smelling
__ lung disease	__ shortness of breath	__ trouble breathing	__ bladder problems	__ trouble sleeping
__ stomach problems	__ constipation	__ diarrhea	__ joint pain	__ problems swallowing
__ high blood pressure	__ dizziness	__ seizures	__ swelling of legs	__ exercise regularly
__ heart disease	__ chest pains	__ have had a blood transfusion in the last 10 years		
__ sexual functioning	__ menstrual problems	__ currently pregnant	__ do breast exams	

__ abortions/miscarriages _____ Past pregnancies _____

Date of last PAP test: _____ Date of last prostate exam: _____ Date of last physical: _____

__ Special diet (check if on a special diet and explain)

__ weight loss how much: _____ in how long: _____

__ weight gain how much: _____ in how long: _____

__ drink alcohol how much: _____ how often: _____

__ have any presence of pain and explain _____

__ use a condom during sexual intercourse __ history of IV drug use and/or sharing of needles

__ physical disabilities _____

List the item number check from above and explain in detail your medical condition:

_____ _____

_____ _____

Medical Hospitalizations

Medical Hospitalizations	Dates	Reason

Family History

Has any member of your family had physical or mental diagnoses? __ Yes (if yes, please explain below) __ No

_____

Client Signature: _____ Date: _____

Clinician Signature: _____ Date: _____