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 Pronouns

Preferred Name: _____ **Maiden Name**: _____ **Date of Birth**: _____

Social Security Number: _____ **Home Phone**: _____ **Cell Phone**: _____

Address (incl. city, state, zip): _____

Email Address: _____

Sex at birth: [ ] M [ ] F [ ] Intersex **Gender**: [ ] M [ ] F [ ] Transgender [ ] Non-Binary [ ] Other _____

Employment Status: [ ] Full-Time [ ] Part-Time [ ] Disabled [ ] Homemaker [ ] Engaged in Residential/Hospitalization
[ ] Jail/Prison/Corrections Inmate [ ] Retired [ ] Not in Labor Force [ ]Student [ ] Volunteer Worker [ ] Actively Seeking 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 [ ] School
[ ] Other Health Care Provider [ ] Employer/EAP [ ] Child Welfare (CSB, OJFS) [ ] 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 Housinq

Racial or ethnic group? [ ] Caucasian [ ]African-American [ ] Other Single Race [ ] Two or More Races
[ ] Native Hawaiian/Pacific Islander [ ] Asian [ ] American Indian
Sexual Orientation: [ ] Heterosexual [ ] Gay/Lesbian [ ] Bisexual [ ] Pansexual [ ] Asexual [ ] Other:_____

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 [ ] Other: _____

Military Status: [ ] None [ ] Active [ ] Discharged [ ] Disabled Veteran
Military Service: [ ] Served in Iraq [ ] Served in Afghanistan [ ] Other combat service [ ] Not Applicable
What is your citizenship status? [ ] US citizen [ ] Student VISA [ ] Other VISA [ ] None of the 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 anv 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/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 OHS 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 and number all conditions which currently apply or have previously applied

[ ] problems w/ vision	[ ] headaches	[ ] blurriness	[ ] wear glasses	[ ] diabetes
[ ] problems w/ hearing	[ ] ringing in ears	[ ] wear hearing aid	[ ] difficulty walking	[ ] problems w/ 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	[ ] blood transfusion in	[ ] heart disease	[ ] currently pregnant
[ ] sexual functioning	[ ] menstrual problems	last 10 years	[ ] breast exams	

[ ] abortions/miscarriages _____ past pregnancies: _____

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

[ ] special diet _____

[ ] weight loss how much: _____ in how long: _____

[ ] weight gain how much: _____ in how long: _____

[ ] drink alcohol how much: _____ in how long: _____

[ ] presence of pain (explain) _____

[ ] use condom during sexual intercourse [ ] history of IV drug use and/or sharing needles

[ ] physical disabilities _____

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

____ _____

____ _____

____ _____

Medical Hospitalizations

Medical Hospitalization	Date	Reason

Family History

Has any member of your family had any physical or mental diagnoses? [ ] Yes (please explain below) [ ] No

_____ _____

Client Signature Date

_____ _____

Clinician Signature Date