**New Horizons Mental Health Services Health History Form**

**Client Name**: **Date of Birth:**

**Age:** **Height: Weight:** **Date of Last Physical Exam:**

**Check all conditions that you have been diagnosed with:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Diagnosis** | **Past** | **Now** | **If yes, explain and list the doctor(s) who diagnosed the condition** | | | |
| Asthma |  |  |  | | | |
| Anemia |  |  |  | | | |
| Arthritis |  |  |  | | | |
| Bleeding Disorder |  |  |  | | | |
| Diabetes |  |  |  | | | |
| Epilepsy |  |  |  | | | |
| Seizures |  |  |  | | | |
| High or Low Blood Pressure  **(Circle one)** |  |  |  | | | |
| Stroke |  |  |  | | | |
| Heart Disease |  |  |  | | | |
| Cancer-Type: |  |  |  | | | |
| Dental Issues |  |  |  | | | |
| Learning Problems |  |  |  | | | |
| Kidney or Lung Disease |  |  |  | | | |
| Stomach or Bowel Problems  **(Circle one)** |  |  |  | | | |
| Fibromyalgia |  |  |  | | | |
| Eye Disease |  |  |  | | | |
| Headaches or Migraines  **(Circle one)** |  |  |  | | | |
| Thyroid Dysfunction |  |  |  | | | |
| Tuberculosis |  |  |  | | | |
| Eating Disorder |  |  |  | | | |
| Sleep Disorder |  |  |  | | | |
| **Special Populations. Please check all that apply.** | | | | | |
| **No Special Population** | |  | |  |
| Speech Impaired |  | Severe Mental Disorder/Severe Emotional Disturbance | |  |
| Blind or Visually Impaired |  | Early Childhood Risk for Severe Emotional Disturbance | |  |
| Language Barriers/English as a Second Language |  | Physical Abuse Victim | |  |
| Deaf or Hearing Impaired |  | Sexual Abuse Victim | |  |
| Developmental Disability |  | Domestic Violence Victim/Witness | |  |
| Physically Disabled |  | Child of Alcohol/Drug User | |  |
| Military Family/Dependent |  | Multiple Service System Involvement | |  |
| Forensic/Legal Status |  | In Custody of Children’s Services | |  |
| Sexual Offender |  | Gay/Lesbian/Bisexual | |  |
| Alcohol/Other Drug Use |  | Non-Conforming Gender Identity | |  |
| Suicidal |  | Hepatitis C | |  |
| Traumatic Brain Injury |  | HIV/AIDS | |  |

Are you currently prescribed any medications by providers **NOT** employed by New Horizons or taking any over-the-counter medications, vitamins, or herbals? No Current Medications

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **Prescriber** | **Reason** | **How long have you been taking this medication?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Do you have any food or drug allergies? No Known Allergies

|  |  |
| --- | --- |
| **Drug/Food/Other** | **Please describe reaction/side effects** |
|  |  |
|  |  |
|  |  |
|  |  |

Have you had any hospitalizations or surgeries in the past three years? None

|  |  |  |
| --- | --- | --- |
| **Hospital** | **Reason/Procedure** | **Dates** |
|  |  |  |
|  |  |  |
|  |  |  |

**Substance Use – Current and Past History** None

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Substance** | **Never** | **Past Use** | **Current Use** | **How long have you used?** | **Have you received treatment?**  **If so, where?** |
| Alcohol |  |  |  |  |  |
| Amphetamines |  |  |  |  |  |
| Benzodiazepines |  |  |  |  |  |
| Caffeine |  |  |  |  |  |
| Marijuana/Cannabinoids |  |  |  |  |  |
| Cocaine/Crack |  |  |  |  |  |
| Hallucinogens |  |  |  |  |  |
| Inhalants |  |  |  |  |  |
| Nicotine |  |  |  |  |  |
| Opiates/Heroin/Pain Medication |  |  |  |  |  |
| OTC Meds |  |  |  |  |  |
| PCP |  |  |  |  |  |
| Prescription Medication |  |  |  |  |  |
| Synthetic Drugs |  |  |  |  |  |

**Do you use Tobacco products?**

Yes

No

Unknown

**Sexual Orientation-**Do you think of yourself as:

Straight or heterosexual

Lesbian or gay

Bisexual

Prefer to self-describe:

Choose not to disclose

**Gender identity**-What is your current gender identity?

Male

Female

Transgender Male/Trans Man/ Female-to-Male (FTM)

Transgender Female/Trans Woman/ Male-to-Female (MTF)

Genderqueer/Non-binary, Gender fluid, neither exclusively male nor female

Additional Gender Category/Prefer to self-describe:

Choose not to disclose

**What sex were you assigned at birth?**

Male

Female (If selected, the questions below will be required)

Choose not to disclose

**Childbirth in the last 5 years?**

Yes

No

Unknown

**Are you currently pregnant?**

Yes

No

Unknown

**What is your stage of pregnancy?**

1st Trimester

2nd Trimester

3rd Trimester

Unknown

**What is your lifetime number of births, both live and still births? Enter 99 if Unknown**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Number of Children in Household under 18? Enter 99 if Unknown**

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