CLIENT HEALTH ASSESSMENT

HYDE PARK COUNSELING PROFESSIONALS

Date: _____

Name _____ Birth Date: _____

Cell Phone: _____ Email: _____

Health History *(please check all that apply):*

- ☐ Anxiety
- ☐ Asthma
- ☐ Back Injuries
- ☐ Bleeding Disorder
- ☐ Chronic Dental Pain
- ☐ Chronic Pain (_____)
- ☐ Depression
- ☐ Diabetes (diet or insulin)
- ☐ Emphysema, Pneumonia, Bronchitis
- ☐ Enteritis/Colitis/Diverticulitis
- ☐ Epilepsy
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Personality Disorder (_____)
- ☐ PTSD (Post Traumatic Stress Disorder)
- ☐ Kidney and liver disease
- ☐ Ulcers
- ☐ Other _____
- ☐ Other _____

What prescribed medications do you take regularly? *Please list all medications.*

_____

_____

On average, how many hours of undisturbed sleep do you get per night? _____

Do you have supportive friends or family that you can be totally honest with and seek support from? Yes ☐ No ☐

When, if ever, have you experienced violence in your home?

☐ Never ☐ Rarely ☐ Occasionally ☐ Often *Please explain the circumstances of the last time you experienced violence in your home.*

_____

_____

Have you ever received mental health treatment? No ☐ Yes ☐ *If yes, when?* _____

_____

In the last 4 weeks, how much have you been bothered by …?	Not bothered	Bothered a Little	Bothered a Lot	
Difficulties with your partner/significant other	0	1	2	Cho
The stress of taking care of children, parents, or other family members	0	1	2	Cho
Stress at work outside of the home or at school	0	1	2	Cho
Financial problems or worries	0	1	2	Cho
Having no one to turn to when you have a problem	0	1	2	Cho
Something bad that happened recently	0	1	2	Cho
Thinking or dreaming about something terrible that happened to you in the past	0	1	2	Cho
Physical Pain	0	1	2	Cho

TO BE FILLED OUT BY COUNSELOR Total Living Concerns _____

Over the *last two weeks*, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly everyday	
Feeling nervous, anxious, or on edge	0	1	2	3	Cho
Not being able to stop or control worrying	0	1	2	3	Cho
Worrying too much about different things	0	1	2	3	Cho
Having trouble relaxing	0	1	2	3	Cho
Being so restless that it is hard to sit still	0	1	2	3	Cho
Becoming easily annoyed or irritable	0	1	2	3	Cho
Feeling afraid as if something awful might happen	0	1	2	3	Cho

TO BE FILLED OUT BY COUNSELOR Total _____ (ten and above)

Excerpt from the Brief Patient Health Questionnaire Patient Health Questionnaire (Anxiety, Adapted from GAD-7)

Over the *last two weeks*, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly everyday	
Little interest or pleasure in doing things	0	1	2	3	Cho
Feeling down, depressed or hopeless	0	1	2	3	Cho
Trouble falling or staying asleep, or sleeping too much	0	1	2	3	Cho
Feeling tired or having little energy	0	1	2	3	Cho
Poor appetite or overeating	0	1	2	3	Cho
Feeling bad about yourself or that you're a failure	0	1	2	3	Cho
Trouble concentrating on things, such as reading the newspaper or watching tv	0	1	2	3	Cho
Moving or speaking so slowly that other people could have noticed or the opposite- being so fidgety or restless that you've been moving around more than usual	0	1	2	3	Cho
Thoughts that you would be better off dead, or thoughts of hurting yourself	0	1	2	3	Cho

TO BE FILLED OUT BY COUNSELOR Total _____ (10+) (If greater than 0, complete Suicide Severity Rating Scale on last page)
Excerpt from the Patient Health Questionnaire (Depression, Adapted from PhQ 9)

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that *in the last month*, you…?			
Have had nightmares about it or thoughts about it when you did not want to?	Yes	No	Choo
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No	Choo
Were constantly on guard, watchful, or easily startled?	Yes	No	Choo
Felt numb or detached from others, activities, or your surroundings?	Yes	No	Choo

TO BE FILLED OUT BY COUNSELOR Total _____ (3+) Excerpt from the Patient Health Questionnaire (PTSD, Adapted from PC-PTSD)

In the past 12 months….	0	1	2	3	4	
	Circle the number of times					
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times a week	4+ times per week	Choose
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	Choose
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	Choose
How often do you take prescription medications that were either not prescribed to you or in an amount greater than prescribed?	Never	Monthly or less	2-4 times per month	2-3 times a week	4+ times per week	Choose
If so, which one(s)?	_____					
How often do you use tobacco products?	Never	Monthly or less	2-4 times per month	2-3 times a week	4+ times per week	Choose
How often do you use illegal drugs?	Never	Monthly or less	2-4 times per month	2-3 times a week	4+ times per week	Choose
If so, which one(s)?	_____					

TO BE FILLED OUT BY COUNSELOR Total _____ (7+) consistent with SUD

Excerpt from the Substance Use Questionnaire (Adapted from AUDIT-C & NM ASSIST) Substance Use Questionnaire (Adapted from AUDIT-C & NM ASSIST)

In the past month …	*Circle Yes or No*		
Have you ever wished you were dead or wished you could go to sleep and not wake up?	Yes	No	Choc
Have you actually had any thoughts of killing yourself?	Yes	No	Choc
Have you been thinking about how you might kill yourself?	Yes	No	Choc
Have you had these thoughts and had some intention of action on them?	Yes	No	Choc
Have you ever done anything, started to do anything, or prepared to do anything to end your life? *If yes, how long ago?* _____	Yes	No	Choc

Columbia-Suicide Severity Rating Scale (Screening Version)

Is there anything else that you feel the counselor should know about you?

_____

_____

_____