

CLIENT HEALTH ASSESSMENT

Date: _____

Name _____ Birth Date: _____

Cell Phone: _____ Email: _____

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

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

ASSESSMENT QUESTIONS

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
The stress of taking care of children, parents, or other family members	0	1	2
Stress at work outside of the home or at school	0	1	2
Financial problems or worries	0	1	2
Having no one to turn to when you have a problem	0	1	2
Something bad that happened recently	0	1	2
Thinking or dreaming about something terrible that happened to you in the past	0	1	2
Physical Pain	0	1	2

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
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Having trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

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 <i>last two weeks</i> , 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
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you're a failure	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching tv	0	1	2	3
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
Thoughts that you would be better off dead, or thoughts of hurting yourself	0	1	2	3

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 <i>in the last month</i> , you...?		
Have had nightmares about it or thoughts about it when you did not want to?	Yes	No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
Were constantly on guard, watchful, or easily startled?	Yes	No
Felt numb or detached from others, activities, or your surroundings?	Yes	No

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

<i>In the past 12 months....</i>	0	1	2	3	4
	<i>Circle the number of times</i>				
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
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
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often do you take prescription medications that were either not prescribed to you or in an amount greater than prescribed? <i>If so, which one(s)?</i>	Never	Monthly or less	2-4 times per month	2-3 times a week	4+ times per week
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
How often do you use illegal drugs? <i>If so, which one(s)?</i>	Never	Monthly or less	2-4 times per month	2-3 times a week	4+ times per week

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)

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

Columbia-Suicide Severity Rating Scale (Screening Version)

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