WESTERN PACIFIC PSYCHOLOGICAL NETWORK INC.
Health Information Form

The purpose of this questionnaire is to obtain a more comprehensive picture of your background. Complete the following questions thoughtfully so that we can provide you with kind of services that you need. Since this information is highly personal, it will become a part of your confidential health record.

1. GENERAL INFORMATION

Name:_____Date:_____

Date of Birth:_____ Age: _____ Sex: _____ Phone Number:_____

Cell Phone Number: _____

Address _____

Current Employer: _____ Position: _____

Marital Status:❑ Single ❑ Engaged ❑ Married ❑ Significant Other ❑ Separated ❑ Divorced ❑ Widowed

Do you have any children? ❑ No ❑ Yes

If yes, please provide gender(s) and age(s) of your child/children _____
_____
_____

Ethnicity: _____

Highest Level of Education Completed :_____

Military Service: ❑ No ❑ Yes if yes, please indicate dates of service _____

Current and past occupations:_____
_____

In case of emergency notify: _____ Phone #: _____

2. PERSONAL AND SOCIAL HISTORY

(a) Date of Birth: _____Place of Birth: _____

(b) Siblings: # of Brothers: _____ Brothers' Ages: _____# of Sisters: _____ Sisters' Ages: _____

(c) Father: Occupation _____ Health: _____ If alive, present age: _____

If deceased, age at time of death: ____ How old were you at the time? ____ Cause of Death: _____

(d) Mother: Occupation _____ Health: _____ If alive, present age: _____
If deceased, age at time of death: ____ How old were you at the time? ____ Cause of Death: _____

(e) If both parents are alive, please indicate the marital status of your parents: **Married** □ **Divorced** □ **Separated** □ **Never Married**

(f) Please list family history of mental illness and alcohol or chemical abuse. _____
_____

_____

(g) Are you currently involved in any litigation? If yes, please explain: _____
_____

(h) Have you ever been arrested (please include date(s) and reason(s)) _____
_____
_____

(i) Have you ever had a prior work injury case or cases? If yes, please provide name of employer, year injured, body areas injured, treatments received including surgeries, hospitalizations, and psychological treatments, etc.
_____
_____
_____

(j) Have you ever been injured in a car accident? If yes, please provide year of accident, body areas injured, treatments received including surgeries, hospitalizations, and psychological treatments, etc.
_____
_____
_____

SYMPTOM CHECKLIST

Please answer whether or not you are experiencing any of the following symptoms:

Sadness/Depression……	❑ **No** ❑ **Yes**
Hopelessness……..	❑ **No** ❑ **Yes**
Suicidal Thoughts/Impulses……...	❑ **No** ❑ **Yes**
Homicidal Thoughts/Impulses……...	❑ **No** ❑ **Yes**
Sleep Problems……..	❑ **No** ❑ **Yes**
Appetite Changes……..	❑ **No** ❑ **Yes**
Inability to Concentrate/Focus……..	❑ **No** ❑ **Yes**
Bothersome/Repetitive Thoughts/Behaviors……	❑ **No** ❑ **Yes**
Panic/Anxiety……	❑ **No** ❑ **Yes**
Relationship Problems……...	❑ **No** ❑ **Yes**
Employment Problems……..	❑ **No** ❑ **Yes**
Memory Problems…….	❑ **No** ❑ **Yes**
Physical Complaints……..	❑ **No** ❑ **Yes**
Anger/Irritability……	❑ **No** ❑ **Yes**
Isolation/Social Withdrawal……..	❑ **No** ❑ **Yes**
Phobia……	❑ **No** ❑ **Yes**
Binging/Purging……	❑ **No** ❑ **Yes**
Poor Impulse Control……	❑ **No** ❑ **Yes**
Acts of Violence……	❑ **No** ❑ **Yes**
Strange/Unusual Thoughts/Behaviors……..	❑ **No** ❑ **Yes**
Self-Harm/Mutilation……...	❑ **No** ❑ **Yes**
Sexual Problems……..	❑ **No** ❑ **Yes**

Other, please describe_____

4. HEALTH HISTORY

(a) Have you ever been diagnosed/considered to be disabled in any way? ❑ No ❑ Yes

Please check those that apply to you:

___ Acquired Brain Injury ___ ADD/ADHD ___ Mobility Impairment _____
___ Hearing Impairment ___ Blind/Visual Impairment
___ Learning Disability ___ Other _____

(b) Have you had previous counseling? ❑ No ❑ Yes

If yes, indicate your age when it began, duration and reason _____

_____

Was it helpful? _____

(c) Are you currently seeing a psychotherapist or psychiatrist? ❑ No ❑ Yes

If yes, please write the name(s) and phone number(s) of your clinicians _____

If yes, indicate your age when it began, duration and reason _____

_____

(d) Are you currently seeing a private physician (PCP)? ❑ No ❑ Yes

If yes, please write the name and phone number of the physician _____.

(e) Are you currently taking any prescribed medications? ❑ No ❑ Yes

If yes, please write the name(s) of the prescribing physician(s). _____

If yes, list the name of the medication(s), dosage(s), length of time taking medications and the condition(s) for which it is prescribed. _____

_____

(f) Have you ever been hospitalized before? ❑ No ❑ Yes

If yes, please indicate if hospitalization was for ❑ Medical and/or ❑ Psychological reasons and provide a brief description of your hospital stay including reasons, length, and resolution. _____

_____

5. SUBSTANCE USE

(a) Please list any current substance (drugs) or alcohol use: _____

_____

_____

(b) How often did you have a drink containing alcohol in the past year? (**Check one**)

_____ Never
_____ Monthly or less
_____ 2 to 4 times a month
_____ 2 to3 times a week
_____ 4 to 5 times a week
_____ 6 or more times a week

(c) How many drinks did you have on a typical day when you were drinking in the past year? (**Check one**)

_____ 0 drinks
_____ 1 to 2 drinks
_____ 3 to 4 drinks
_____ 5 to 6 drinks
_____ 7 to 9 drinks
_____ 10 or more drinks

(d) How often did you have 4 or more drinks on one occasion in the past year? (**Check one**)

_____ Never
_____ Less than monthly
_____ Monthly
_____ Weekly
_____ Daily or almost daily

(e) Have you used any drug in the past 30 days that was not prescribed to you by a doctor *(for example; marijuana, methamphetamine, cocaine, diet pills, ecstasy, Xanax, Valium, Ritalin, Adderall, LSD, acid, mushrooms, heroin, codeine, etc.)*? (**Check one**)

_____ No **_____ Yes**

Revised: 08/31/2013