Sobriety Centers of New Hampshire

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Sobriety Centers of New Hampshire | Outpatient Program
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Health History Form

Name: _____ Date of Birth: ____-____-_____

Reason for today's visit: _____

CURRENT MEDICATIONS

Name of Medications	**Strength** (ex. 500 mg)	**Dosing Instructions** (ex. Twice a day)

ALLERGY HISTORY

☐No Known Allergies ☐Medication Allergies ☐Environmental/Seasonal Allergies ☐Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	**Reaction** (ex. Rash, Nausea, Respiratory, Shock, etc.)

SOCIAL HISTORY *(Please circle all applicable responses.)*

Marital Status	Single Significant Other Married Divorced Widowed
Sexual Orientation	Heterosexual Gay Lesbian Bisexual Transgender
Living Situation	Alone Spouse/Significant Other Children/Family Homeless Residential Other:
[Females] Are you pregnant?	Yes / No Hysterectomy Menopause Tubal Ligation
What are your hobbies?	
Education (highest level)	9 10 11 12 Some College Associates Bachelors GED Masters PhD
Employment?	Full-Time Part-Time Unemployed Seeking employment Disabled Retired
If yes, Employer:	Occupation:
Previous work experience?	Yes / No If yes, description:

Military History	None / Past / Current Army Navy Marines Coast Guard Retired
Combat?	Yes / No If yes, where?
Discharge?	Yes / No If yes: Honorable Dishonorable General Retired Other
VA Disability?	Yes / No If yes, due to:
Spiritual/Religious Affiliation?	Yes / No Practicing / Role of Faith Past & Present?
Receiving Benefits?	Yes / No APTD SSI SSDI Food Stamps Fuel Asst. Section 8 Disability Public/HUD Housing PASS Plan Workers Comp Unemployment

Tobacco Use? If no, have you ever?	Yes / No Yes / No	Cigarettes / Cigars / Chew Cigarettes / Cigars / Chew	Per day: Per day:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea Soda / Energy Drink	Per day:
Do you exercise?	Yes / No	Type?	Per day:
Do you wear your seatbelt?	Yes / No	If yes, percent of time:	

MEDICAL HISTORY

(Please check any of the following that you have or have had in the past.)

____ Acid Reflux/GERD	____Cancer	____Headaches	____Liver Disease
____ ADHD	____ Chronic Cough	____Hearing Loss	____Osteoporosis
____ Alcoholism	____Chronic Pain	____ Heart Disease	____ Seizure Disorder
____Anemia	____ STD	____Hepatitis	____ Anxiety
____ COPD/Emphysema	____ Dementia	____High BP	____ Stroke
____ Asthma	____ Diabetes	____HIV/AIDS	____ Thyroid Disease
____ Bleeding Disorders	____ Eating Disorders	____ Kidney Disease	____ Tuberculosis
____ Glaucoma/Cataracts	____ Bowel Problems	____ Immune Disorders	____ Other:_____

- Are you/do you have:
  Obsessive compulsive? _____ Eating disorder? _____ Panic Attacks? _____
- Have you had Hepatitis? ☐Yes ☐No Venereal Disease? ☐Yes ☐No
- Have you participated in high-risk sexual practices? _____
  If so, please describe: _____
- Do you now have, or have you ever had, seizures or convulsions? ☐Yes ☐No
  If yes, when, and what condition caused them? _____

When was the last seizure or convulsion?_____

For Women Only:

At what age did you start to menstruate? _____

Do you now have, or have you had, any problems with your menstrual period? ☐Yes ☐No

If yes, please describe these problems: _____

Have you had any:

Pregnancies? ☐Yes ☐No If yes, how many? _____ When? _____ Were you using? ____

Miscarriages? ☐Yes ☐No If yes, how many? _____ When? _____ Were you using? ____

Abortions? ☐Yes ☐No If yes, how many? _____ When? _____ Were you using? ____

Menopausal symptoms or treatment? If yes, when? _____

For Men Only:

Do you now have, or have you had, problems with your prostate, difficult or painful urination, or impotence? ☐Yes ☐No If yes, please describe those problems: _____

Family History *(Please tell us about your immediate family.)*

CHILDREN: ☐None

First Name	Last Name	Age	Living With?	Custody?	Quality of Relationship

SPOUSE/SIGNIFICANT OTHER: ☐None

First Name	Last Name	Age	Occupation?	Quality of Relationship
Mother				
Father				
Sibling:				

Sibling:				
Sibling:				
Other:				

Place of birth: _____ Place of upbringing: _____

Family is: Intact Parents Separated/Divorced Parents Remarried

Resides with: Mother Father Adopted Orphaned Other:_____

Health History	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy					
Asthma					
Blood Disease					
Other:					

Contact with Family (Check all that apply.)

☐ Visit at least monthly
☐ Family is available locally
☐ Knowledge about mental illness
☐ Non-Supportive
☐ Involved with treatment providers
☐ Supportive
☐ Family members not available
☐ Involved in NAMI or other support group ☐
Satisfied with family/relationship contact

SUBSTANCE ABUSE HISTORY

Family Substance Abuse (Please check any family that apply, and list substance abused.)

☐ None ☐ Parents: _____ ☐ Siblings: _____ ☐ Extended Family: _____

Do you or your family think you have a problem with:

Shopping? ☐ Yes ☐ No Barbiturates? ☐ Yes ☐ No Internet? ☐ Yes ☐ No

Sex Addiction? ☐ Yes ☐ No Gambling? ☐ Yes ☐ No

Have you had any previous rehab or treatment of substance abuse? ☐ Yes ☐ No

Where?	Reason there?	How long?	In patient/ Outpatient?	Date

(Please indicate which of the following drugs you have used, if any.)

Substance	Age at first use	How often you use	How much you use	Method(s) you use	How long since last use
Alcohol					
Methamphetamines					
Amphetamine					
Barbiturates					
Cocaine (powder)					
Cocaine (crack)					
Hallucinogens					
Heroin					
Methadone					
Opium					
Inhalants					
Marijuana/Hashish					
PCP (Angel Dust)					
Ketamine (Special K)					
Ecstasy (x)					
Morphine					
Other: _____					

Did/do you go to "meetings"? _____ Do you have a sponsor? _____
Do you see a psychiatrist and if so who and for how long? _____
Do you see a therapist or counselor and if so who and how long? _____
Have you ever been treated for depression and if so when? _____

LEGAL HISTORY *(Please report any and all legal issues.)*

Legal or Criminal Involvement?	☐ Yes ☐ No	Court Order Probation Parole Restraining Order Found not competent to stand trial Homicide Attempted Homicide Sexual Assault Arson Assault Felony
Probation/Parole Officer:	Current / Past	Name: _____County: _____
DUI (date):	**Warrants** (date):	**Violent Crime** (date):

Incarceration (dates):	How long:	Reason:
Do you have firearms at home?	☐Yes ☐No	If yes, are they locked? ☐Yes ☐No

MENTAL HEALTH

Stressful events over the last year:

____ Recent Hospital Discharge ____ Access to Healthcare ____ Financial Problems
____ Death/ Divorce/ Separation ____Legal Problems ____ Relationship Problems
____ Witness/ Victim of Violence ____ Disability (self or family)____ Move
____ Other Family Problems ____ Educational Problems ____ Parenting Issues
____ Health Problem: _____ ____ Housing Problems ____ Job Loss
____ History/Current Abuse ____ Social/Environment Problems ____ Other: _____

Please check symptoms experienced in the last 4 weeks:

MOOD ☐Depression ☐Anxiety ☐Hopelessness	☐Mood Changes ☐Sadness ☐Elation (happier than normal) ☐Anger / Rage	☐Overwhelming guilt / shame ☐Difficulty enjoying life ☐Irritability
BEHAVIORS ☐Hurting yourself ☐Doing the same thing repeatedly	☐Uncontrolled spending / gambling ☐Increased alcohol / drug use	☐Reckless Behavior ☐Social Isolation
PHYSICAL ☐Increased Sleep ☐Decreased Sleep ☐Difficulty Sleeping	☐Panic / Anxiety Attacks ☐Increased Appetite / Weight Gain ☐Decreased Appetite / Weight Loss ☐Disturbing nightmares/dreams	☐Agitation / Restlessness ☐Social Isolation
THINKING ☐Wanting to take your life ☐Wanting to hurt someone else ☐Seeing / Hearing things that	☐Intrusive negative thoughts ☐Flashbacks ☐Irrational Fear ☐Racing Thoughts ☐Paranoia	☐Low Self-Esteem ☐Academic/Work Problems ☐Easily Distracted ☐Thinking same thought repeatedly

aren't there ☐ Difficulty concentrating		☐ Memory Problems
INTERPERSONAL ☐ Increased conflict with others ☐ Increased family conflict ☐ Difficulty making/keeping friends	☐ Socially withdrawn / Isolation ☐ Increased sexual concern or problems ☐ Increased social anxiety ☐ Problems with intimacy	☐ Increased difficulty tolerating others ☐ Trouble with law/authority figures ☐ Intermittent relationships

TREATMENT QUESTIONNAIRE

Have you had any previous **psychiatric hospitalizations**? ☐ Yes ☐ No

Where	When	Reason

Have you had any previous **outpatient mental health treatment**? ☐ Yes ☐ No

Where	When	Reason

Have you had any previous **prescribed psychiatric medications**? ☐ Yes ☐ No

Medication	Prescribing Doctor	Dates

Have any family members had a history of **mental illness**? ☐ Yes ☐ No

Person	Diagnosis or Symptoms	Treatments

Have you ever experienced any **trauma**? ☐ Yes ☐ No

If yes, have you been:

☐ Neglected ☐ Physically Abused ☐ Emotionally Abused

☐ Sexually Abused ☐ Acts of War ☐ Serious Accidents ☐ Other

☐ Witness/Victim of Violence ☐ Fire ☐ Don't know

Describe:

How are you **sleeping**?
(Describe any recent changes or problems.)

How is your **appetite**?
(Include any recent weight changes.)

What **leisure or stress reduction activities** do you use?

Past **interests / activities**:

Do symptoms interfere with your ability to work or get things done? ☐ Yes ☐ No

Additional Comments / Information:

The above information is thorough and accurate to the best of my knowledge.

_____ _____

Patient Signature (or Guardian) **Date**