

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 or your family Member(s) have been diagnosed with:

| <i>Condition</i> | <i>Self</i> | <i>Mother</i> | <i>Father</i> | <i>Grandparent</i> | <i>Sibling</i> |
|----------------------------------|-------------|---------------|---------------|--------------------|----------------|
| <i>Asthma</i> | | | | | |
| <i>Anemia</i> | | | | | |
| <i>Arthritis</i> | | | | | |
| <i>Bleeding Disorder</i> | | | | | |
| <i>Diabetes</i> | | | | | |
| <i>Epilepsy</i> | | | | | |
| <i>Seizures</i> | | | | | |
| <i>High Blood Pressure</i> | | | | | |
| <i>Low Blood Pressure</i> | | | | | |
| <i>Stroke</i> | | | | | |
| <i>Heart Disease</i> | | | | | |
| <i>Cancer- Type</i> | | | | | |
| <i>Dental Issues</i> | | | | | |
| <i>Learning Problems</i> | | | | | |
| <i>Kidney Disease</i> | | | | | |
| <i>Lung Disease</i> | | | | | |
| <i>Stomach or Bowel Problems</i> | | | | | |
| <i>Fibromyalgia</i> | | | | | |
| <i>Eye Disease</i> | | | | | |
| <i>Headaches or Migraines</i> | | | | | |
| <i>Thyroid Dysfunction</i> | | | | | |
| <i>Tuberculosis</i> | | | | | |
| <i>Eating Disorder</i> | | | | | |
| <i>Sleep Disorder</i> | | | | | |
| <i>ADD/ADHD</i> | | | | | |
| <i>Anxiety</i> | | | | | |
| <i>Bipolar Disorder</i> | | | | | |
| <i>Depression</i> | | | | | |
| <i>Schizophrenia</i> | | | | | |

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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 |
|-----------------|---------------------------------------|
| | |
| | |
| | |

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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 | | | | | |

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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
