

New Horizons Mental Health Services Health History Form

Client name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Date of last physical exam: _____

Medical condition(s) the client has been diagnosed with (check all that apply) None

| Diagnosis | ICD-10 Code (Office Use Only) | Client Past | Client Now | Doctor who diagnosed the condition |
|-------------------------------|----------------------------------|----------------|---------------|---------------------------------------|
| | | *** | *** | |
| Asthma | J45.909 | | | |
| Liver Disease | K76.9 | | | |
| Diabetes | E11.9 | | | |
| Epilepsy | G40.909 | | | |
| Seizures | R56.9 | | | |
| Brain Injury | S06.9X9A | | | |
| Tumor | D49.6 | | | |
| Heart Disease | I51.9 | | | |
| Hepatitis | K75.9 | | | |
| Stroke | I63.9 | | | |
| HIV Positive | Z21 | | | |
| Cancer (Please Indicate Type) | | | | |
| | | | *** | |
| Anemia | D64.9 | | | |
| Arthritis | M19.90 | | | |
| Bleeding Disorder | D68.9 | | | |
| High Blood Pressure | I10 | | | |
| Low Blood Pressure | I95.9 | | | |
| Eye Disease | H57.9 | | | |
| Fibromyalgia | M79.7 | | | |
| Glaucoma | H40.9 | | | |
| Headaches | R51 | | | |
| Migraines | G43.909 | | | |
| Hearing Loss | H91.90 | | | |
| Kidney Disease | N28.9 | | | |
| Lung Disease | J98.4 | | | |
| Dental Issues | Z87.19 | | | |
| Stomach | K31.9 | | | |
| Bowel Problem | K 63.9 | | | |
| Thyroid Dysfunction | E07.9 | | | |
| Tuberculosis | A15.9 | | | |
| Sexually Transmitted Disease | A64 | | | |
| Learning Problems | F81.9 | | | |
| Speech Problems | R47.9 | | | |
| Eating Disorder | F50.9 | | | |
| Sexual Problems | F52.9 | | | |
| Sleep Disorder | G47.9 | | | |
| | | | | |
| Anxiety | | | | |
| Bipolar Disorder | | | | |
| Depression | | | | |
| ADD/ADHD | | | | |
| Schizophrenia | | | | |
| Other: | | | | |

Is the client 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 has the client been taking this medication? |
|------------|--------|------------|--------|------------------------------------------------------|
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Does the client have any food or drug allergies? No Known Allergies

| Drug/Food/Other | Please describe reaction/side effects |
|-----------------|---------------------------------------|
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Is the client currently pregnant or has ever been pregnant? No

| Date of Delivery/ Due Date | Is the client/did the client receive pre-natal care? | Complications |
|-------------------------------|------------------------------------------------------|---------------|
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| | | |

Has the client had any hospitalizations or surgeries in the past three years? None

| Hospital | Reason/Procedure | Dates |
|----------|------------------|-------|
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| | | |

Substance Use of Client – Current and Past History None

| Substance | Never | Past Use | Current Use | How long has the client used? | Has the client 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 | | | | | |

Sexual Orientation

Does the client think of themselves as:

- Straight or heterosexual
- Lesbian, gay, or homosexual
- Bisexual
- Other, please specify: _____
- Don't know
- Choose not to disclose

Gender identity

What is the client's current gender identity? (Check one):

- Male
- Female
- Transgender Male/Trans Man/ Female-to-Male (FTM)
- Transgender Female/Trans Woman/ Male-to-Female (MTF)
- Genderqueer/Non-binary, neither exclusively male nor female
- Additional Gender Category/(or Other), please specify: _____
- Choose not to disclose

What sex was the client assigned at birth on the original birth certificate? (Check one):

- Male
- Female
- Choose not to disclose