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:

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

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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

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Number of Children in Household under 18? Enter 99 if Unknown

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