Mary Clare MS Ed, MSW, LCSW-R
277 Alexander Street Suite 300
Rochester, New York 14607
585-262-2820

Client Health Information

Name:_____ Age:_____ DOB:_____

Name of Primary Care Physician:_____ Phone:_____
Address:_____
Date of last visit:_____Reason:_____

Any current medical problems? Yes No
Briefly describe_____

Any past medical problems? Yes No
Briefly describe_____

List any allergies(especially medications):
_____

Any history of hospitalization? Yes No

When?_____Reason_____

In the last 12 months have you experienced any changes or problems with eating or appetite? Yes No

Any recent changes in weight? Yes No Pounds gained/lost:_____

Any problems with sleeping? Yes No
Getting/staying asleep? Yes No
Average hours of sleep/night:_____

Do you smoke: Yes No Amount_____

Do you drink alcohol? Yes No
How much?_____How often?_____
Do you use other drugs?
What?_____How much?_____How often?_____

Do you drink caffeinated beverages? Yes No
What?_____How much?_____How often?_____

MEDICATIONS

Current prescription medications:

Type	Dose	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

Regular use of non-prescription drugs:

Type	Dose	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your primary care physician or psychiatrist ever prescribed medications for mood, anxiety or depressive symptoms?

Type	Dose	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

MENTAL HEALTH HISTORY

Any family members ever in treatment for or have a history of depressions, anxiety, chemical dependence, or other mental health problems? Yes No
Who?_____

Previous counseling or EAP experience?

When?	With Whom	Purpose	Helpful?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been hospitalized for emotional/psychiatric reasons?Yes No
Briefly describe:_____

Do you have any history of wanting to hurt yourself? Yes No

Have you ever been in treatment for alcohol/substance abuse? Yes No
When?_____Where?_____SubstancesUsed?
_____
_

Have you ever been in treatment for an eating disorder or do you questions whether or not you have an eating disorder? Yes No

Briefly describe:_____

COPING STRATEGIES

Please circle all that apply. When I am under stress I often:

Exercise	Eat	Talk with friends
Smoke	Sleep	Have a drink
Watch TV	Read	Isolate/withdraw
Go out	Work	Become irritable
Meditate	Use humor	Shop
Use the computer	Hit/throw things	Use drugs
Hobby:_____	Other:_____	

Signature:_____Date:_____