Systemic Perspectives Health Assessment

This confidential information is for use by your therapist. Each family member seen in therapy should complete this form. For children under 18 ask receptionist for the Child /Adolescent Assessment form.

Name ____ Date ______________

Name of primary physician____

Would you like us to contact your physician ___ Yes ___ No

Date of last visit _______________ Reason _______________________________________

Current prescribed medications____

____

Check conditions for which you have ever received treatment:

Alcohol Problems ( )	Hypoglycemia ( )	Emotional Problems ( )
Allergies ( )	Sexual Problems ( )	Seizure Disorder ( )
Arthritis ( )	Menstrual/Menopause ( )	Head Injury ( )
Back trouble ( )	Headaches ( )	Hearing Problems ( )
Chronic pain ( )	Pregnancy/Infertility Issues ( )	Thyroid Disease ( )
Digestive Disorder ( )	Diabetes ( )	High Blood Pressure ( )
Heart Disease ( )		Cancer ( )

Vision Problems ( ) Other:____

Health Concerns

Eating Habits ( ) No concern; Concerns:____

____

Sleep/Rest patterns ( ) No concern; Concerns:_______________________________________

____

Physical Exercise ( ) No concern; Concerns:____

____

Physical, Emotional, Sexual Abuse ( ) No concern; Concerns:__________________________

____

Job/Financial Issues ( ) No concern; Concerns:______________________________________

____

Spiritual Life ( ) No concern; Concerns:____

____

Family stressors (marital, children, extended family) ( ) No concern; Concerns ____________

____

Recent losses ____

TURN OVER TO COMPLETE FORM

Patient Name: ______________________________________

Use of Alcohol ____

Nicotine____

Non prescribed drugs ____

Has anyone ever worried about your drug or alcohol use? _________________________

Have you received treatment in the past for drugs or alcohol use? ( ) No ( ) Yes, Specify:

____

Current Problem

Describe the problem(s) that bring you to the clinic at this time _____________________

____

____

____

When did these problems start? ____

Have you ever had therapy in the past? ______ List provider name(s) and date(s) _____

____

____

Have you ever been treated by a psychiatrist? ( ) No ( ) Yes Name and dates of treatment

____

Goals you would like to accomplish while in therapy __________________________________

____

____

____

Anything else you think would be helpful for your therapist to know ______________

____

____