Horizons Mental Health Center
Adult Health History Form

Client's Name:	Date Of Birth:
What are you here for today?	
Who Referred You To Horizons:	Primary Care Physician:
Do You Have Friends and/or relatives working at Horizons?	

CURRENT SYMPTOMS

Please Check any of the following terms that apply to you (S= Self) or with a family member (F=Family)

S F
- ☐ ☐ Depressed mood
- ☐ ☐ Lost interest or pleasure
- ☐ ☐ Lack of energy/fatigue
- ☐ ☐ Weight gain or loss
- ☐ ☐ Unable to concentrate
- ☐ ☐ Difficulty sleeping
- ☐ ☐ Excessive sleeping
- ☐ ☐ Decreased need for sleep
- ☐ ☐ Pressure to keep talking
- ☐ ☐ Nightmares
- ☐ ☐ Racing thoughts
- ☐ ☐ Excessive risk taking behavior
- ☐ ☐ Panic attacks
- ☐ ☐ Excessive fear or situation or object
- ☐ ☐ Reoccurring thoughts or impulses
- ☐ ☐ Repetitive behaviors to reduce stress
- ☐ ☐ Witness/experience event threatening life or serious injury
- ☐ ☐ Excessive anxiety or worry
- ☐ ☐ Hear/see things others do not
- ☐ ☐ Memory problems/ Memory loss
- ☐ ☐ Suicidal thoughts
- ☐ ☐ Sexual problems
- ☐ ☐ Gambling problem
- ☐ ☐ Aggressive behavior toward others
- ☐ ☐ Frequent lying/deceitfulness

S F
- ☐ ☐ Significant ongoing physical pain
- ☐ ☐ Stomach problems
- ☐ ☐ Bowel problems
- ☐ ☐ Balance problems
- ☐ ☐ Seizure problems
- ☐ ☐ Learning/academic problems
- ☐ ☐ Stuttering problems
- ☐ ☐ Frequent problems with attention
- ☐ ☐ Headaches
- ☐ ☐ Cutting
- ☐ ☐ Making Yourself Sick
- ☐ ☐ No Desire To Eat
- ☐ ☐ Eating Too Much
- ☐ ☐ Learning/Academic problems
- ☐ ☐ Schizophrenia
- ☐ ☐ Bipolar Disorder
- ☐ ☐ Anxiety
- ☐ ☐ Alzheimer's
- ☐ ☐ Cancer
- ☐ ☐ Thyroid Disease
- ☐ ☐ Stoke
- ☐ ☐ Diabetes
- ☐ ☐ Hypertension
- ☐ ☐ Heart Disease
- ☐ ☐ Impulsive behaviors
- ☐ ☐ Temper

S F
- ☐ ☐ Problem following rules
- ☐ ☐ Gambling Problems
- ☐ ☐ Alcohol Use
- ☐ ☐ Drug usage
- ☐ ☐ Marital problems
- ☐ ☐ Divorce
- ☐ ☐ Separation
- ☐ ☐ Affair
- ☐ ☐ Problems with ex/spouse
- ☐ ☐ Relationship problems
- ☐ ☐ Frequent "on the go" behavior
- ☐ ☐ Parenting problems
- ☐ ☐ Problems with friends
- ☐ ☐ Problems with children
- ☐ ☐ Legal problems
- ☐ ☐ Work/job problems
- ☐ ☐ Financial problems
- ☐ ☐ School problems
- ☐ ☐ Incarceration
- ☐ ☐ Anger
- ☐ ☐ Loneliness
- ☐ ☐ Insecurity
- ☐ ☐ Isolation
- ☐ ☐ Destructive behavior
- ☐ ☐ Shyness

MEDICAL HISTORY

Please List Any Past or Current Contacts with Doctors, Psychiatrists, or Therapists

Name of Provider	Reason for Service	Dates of Services

Have You Ever Been Hospitalized For Your Mental Health Status? (A1) If So, Please List(Place and Date)

Hospital Name	Place	Dates

Please list all Medications *

Current Medication	Strength/Dose/Schedule	Prescriber/Start Date

*Attach list if you have more meds to list than the space allows

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Please list Previous Psychiatric Medications:	
Please List Any Known Allergies:	
Are you Pregnant?	Current Form of Birth Control?
History Of Serious Illness, Injury or Surgery (Please list):	

Review Of Systems: Please circle if any of the problems apply within the past 30 days:

Numbness/Tingling	Joint Problems	Stomach Pain	Rash or Hives
Headaches	Muscle Pain	Nausea/Vomiting	Eczema
Tremors	Muscle Weakness	Chest Pain	Psoriasis
Dizziness	Kidney Infection/Stone	Rapid Heart Beat	Shortness Of Breath
Vision Problems	Bladder Infection	High/Low Blood Pressure	Involuntary Movements
Hearing Problems	Difficulty Urinating	Weight Gain Or Loss	Fever
Insomnia	Constipation	High/Low Blood Sugar	Other:
Seizures	Diarrhea	Thyroid Problems	Other:

SUBSTANCE USE

Use of Illegal Drugs, Tobacco Products, or Alcohol (Current or Previous use)? ☐ Yes ☐ No

Name of Substance	Age of first Use	Amount and Frequency	Date of last use

SOCIAL HISTORY

Please List Number Of Children and Their Ages Below	Relationship Status :
What Is Your Highest Level Of Education? (A4):	
Name of Employer(A5):	Job Title:
Have you ever served in the Military? ☐ Yes ☐ No	If yes, please list branch:

Have You Been Arrested In The Last 30 Days(A6)? If So, Please List Reason:
Are You Currently Involved With Court Services(A7) (Parole, Community Corrections, Etc) (If So Please List):

Date	Reason	Convicted?

ABUSE HISTORY

Has anyone abused you physically, sexually or emotionally? ☐ Yes ☐ No

Type (Physical/Sexual/Emotional)	When did it start (how old were you?)	Is it Ongoing?

Client or Guardian Signature ________________________________ **Date** ________________

OFFICE USE ONLY:
Signature Of Reviewing Clinical/Medical Staff ____________________________________ Date Reviewed ______

*Attach list if you have more meds to list than the space allows