CONFIDENTIAL
Adult Health History

Please write or print clearly. All of your information will remain confidential between you and the Health Coach.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Email: _____ How often do you check email? _____

Phone: Home: _____ May we leave a message here?: Yes ☐ No ☐

Mobile: _____ May we leave a message here?: Yes ☐ No ☐

Work: _____ May we leave a message here?: Yes ☐ No ☐

Age: _____ Height: _____ Birthdate: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

TERMS OF SERVICE

I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of cancellation, I will be charged the full fee for professional service.

Signed: _____ Date: _____

All accounts are requested to have a credit card on file to reserve appointments. This information will be kept confidential and will only be used to process payments at your request or to bill for late cancellations and missed appointments.

Credit Card Number: _____ Exp. Date: _____

Billing Zip Code: _____ Card Type: ☐ VISA ☐ MASTERCARD

Four Winds
COUNSELING CENTER

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SOCIAL INFORMATION

Relationship status: _____

Where do you currently live? _____

Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

MEDICAL INFORMATION

Primary Physician: _____ City: _____ Zip: _____

Specialty (eg. Family Practice, OB/GYN, Internal Medicine): _____

Are you currently receiving medical treatment? □ Yes □ No If, yes, please specify: _____

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you've had (use back if necessary): _____

_____

_____

List all current medications you are taking, including those you seldom use or take only as needed (use back if necessary).

Medication	Dosage	Purpose for Medication

Are you taking these medication(s) according to your doctor's recommendations? □ Yes □ No

If no, briefly explain: _____

LEVEL OF DISTRESS

Indicate how distressed you are by placing an "X" on the scale below (1= Very Little Distress; 10=Extreme Distress):

1 2 3 4 5 6 7 8 9 10
Very Little Distress Extreme Distress

Are you currently experiencing any suicidal thoughts? □ Yes □ No

Have you experienced them in the past? □ Yes □ No

Have you ever attempted suicide? □ Yes □ No

Have any of your friends or family ever committed or attempted suicide? □ Yes □ No

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FAMILY HISTORY

Please check any of the following physiological symptoms that apply to you presently or in the recent past:

Headaches	□ Past	□ Present	Dizziness	□ Past	□ Present	Stomach Trouble	□ Past	□ Present
Visual Trouble	□ Past	□ Present	Sleep Trouble	□ Past	□ Present	Trouble Relaxing	□ Past	□ Present
Weakness	□ Past	□ Present	Tension	□ Past	□ Present	Rapid Heart Rate	□ Past	□ Present
Difficulty Breathing	□ Past	□ Present	Intestinal Trouble	□ Past	□ Present	Hearing Noises	□ Past	□ Present
Change in Appetite	□ Past	□ Present	Tiredness	□ Past	□ Present	Pain	□ Past	□ Present
Hearing Voices	□ Past	□ Present	Seeing Things	□ Past	□ Present	Other:		

Please check any of the following problems that apply to you and/or your family:

Stress	□ You	□ Family	Nervousness	□ You	□ Family	Anxiety	□ You	□ Family
Panic	□ You	□ Family	Unhappiness	□ You	□ Family	Depression	□ You	□ Family
Guilt	□ You	□ Family	Apathy	□ You	□ Family	Terminal Illness	□ You	□ Family
Recent Death	□ You	□ Family	Grief	□ You	□ Family	Hopelessness	□ You	□ Family
Inferiority Feelings	□ You	□ Family	Defective Feelings	□ You	□ Family	Loneliness	□ You	□ Family
Shyness	□ You	□ Family	Fears	□ You	□ Family	Friends	□ You	□ Family
Marriage	□ You	□ Family	Communication	□ You	□ Family	Physical Abuse	□ You	□ Family
Emotional Abuse	□ You	□ Family	Verbal Abuse	□ You	□ Family	Sexual Abuse	□ You	□ Family
Temper	□ You	□ Family	Anger	□ You	□ Family	Aggressiveness	□ You	□ Family
Bad Dreams	□ You	□ Family	Concentration	□ You	□ Family	Racing Thoughts	□ You	□ Family
Unwanted Thoughts.	□ You	□ Family	Memory	□ You	□ Family	Loss of Control	□ You	□ Family
Impulsive Behavior.	□ You	□ Family	Self-Control	□ You	□ Family	Compulsivity	□ You	□ Family
Sexual Problems	□ You	□ Family	Pregnancy	□ You	□ Family	Abortion	□ You	□ Family
Legal Matters	□ You	□ Family	Trauma	□ You	□ Family	Eating Problems	□ You	□ Family
Drug Use	□ You	□ Family	Alcohol Use	□ You	□ Family	Trouble with Job	□ You	□ Family
Career Choices	□ You	□ Family	Ambition	□ You	□ Family	Making Decisions	□ You	□ Family
Children	□ You	□ Family	Being a Parent	□ You	□ Family	Finances	□ You	□ Family
Recent Loss	□ You	□ Family	Disaster	□ You	□ Family	Other	□ You	□ Family

HEALTH INFORMATION

Please list your main health concerns: ______________________________

____

____

Other concerns and/or goals? ______________________________

____

At what point in your life did you feel best? ______________________________

Any serious illnesses/hospitalizations/injuries? ______________________________

____

What role do sports and exercise play in your life? ______________________________

____

HEALTH INFORMATION (continued)

How is/was the health of your mother? _____

How is/was the health of your father? _____

What is your ancestry? _____ What blood type are you? _____

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness, or swelling? _____

Constipation/Diarrhea/Gas? _____

Allergies or sensitivities? Please explain: _____

FOOD INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

Do you cook? _____ What percentage of your food is home-cooked? _____

Where do you get the rest from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

The most important thing I should do to improve my health is: _____

_____

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WOMEN'S HEALTH (Optional)

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? Please explain: _____

Reached or approaching menopause? Please explain: _____

Birth control history: _____

Do you experience yeast infections or urinary tract infections? Please explain: _____

_____

SENIOR'S HEALTH (Optional)

Do you have Grandchildren? _____

What is your retirement plan? _____

Do you still feel independent? Please explain: _____

_____

Are you a part of a community? Please explain: _____

_____

ADDITIONAL COMMENTS

Anything else you would like to share? _____

_____

_____

_____

I verify that the information provided above is accurate to the best of my knowledge.

Signature: _____ Date: _____