

Sue Genaro Legacy, LCSW
4408 Spicewood Springs Rd., Suite 104
Austin, Texas 78759
Phone: (512) 372-9595

HEALTH HISTORY FORM

Name: _____ Date: _____

SEX: M F Date Of Birth: _____ Yrs. Of Education: _____

1. Please describe the reason(s) you are seeking treatment:

2. When did the problem begin and what motivated you to seek treatment now?

3. On the scale below, please estimate the current severity of the problem(s):

_____ _____ _____ _____
Mildly Upsetting Moderately Severe Very Severe Totally Incapacitating

4. List all past or present mental health treatment:

Dates	Type Of Treatment	Doctor/Therapist Name	Where

5. List all current medications:

6. List all medications taken in the past for emotional/psychiatric reasons and dates taken:

7. Are you allergic to any medication(s)? NO YES If yes, please list.

8. Mark an (X) for any of the following that have ever applied to you:

MEDICAL	MENTAL HEALTH	MENTAL HEALTH
<input type="checkbox"/> AIDS or HIV+	<input type="checkbox"/> alcohol/drug problems	<input type="checkbox"/> juvenile delinquency
<input type="checkbox"/> cancer	<input type="checkbox"/> anorexia	<input type="checkbox"/> physical abuse
<input type="checkbox"/> diabetes	<input type="checkbox"/> bedwetting	<input type="checkbox"/> rape
<input type="checkbox"/> epilepsy	<input type="checkbox"/> behavior problems	<input type="checkbox"/> running away
<input type="checkbox"/> heart trouble	<input type="checkbox"/> binge eating	<input type="checkbox"/> school phobia
<input type="checkbox"/> kidney disease	<input type="checkbox"/> childhood fears	<input type="checkbox"/> sexual abuse
<input type="checkbox"/> liver disease	<input type="checkbox"/> confusion	<input type="checkbox"/> sexual identity
<input type="checkbox"/> mononucleosis	<input type="checkbox"/> family problems	<input type="checkbox"/> sexual problems
<input type="checkbox"/> pancreatitis	<input type="checkbox"/> hyperactivity	<input type="checkbox"/> teenage pregnancy
<input type="checkbox"/> thyroid disease	<input type="checkbox"/> incest	<input type="checkbox"/> truancy
<input type="checkbox"/> venereal disease		

Please describe those checked above:

9. Please list any past or current significant medical problems or mental illnesses (depression, anxiety, chemical dependency, psychiatric hospitalizations, etc.) suffered by your children, brothers and sisters, parents or grandparents:

10. Current Alcohol/Drug Use:

How Often:

11. Ever felt suicidal? YES NO
 Currently? YES NO

Ever felt homicidal? YES NO
 Currently? YES NO

12. What would you like to get out of treatment?
