Behavioral Healthcare Partners of Central Ohio, Inc.

## Health History

| Client Name: | Date: |
|---|---|
| | |

In order to provide the best possible care, Behavioral Healthcare Partners of Central Ohio, Inc. (BHP) is interested in understanding both your physical and behavioral health history and concerns. Please take a moment to complete this form as fully as possible.

**Health History: Have you ever had any of the following health conditions?**

| Condition | | | | | | |
|---|---|---|---|---|---|---|
| **Anemia** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Arthritis** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Asthma** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Bleeding Disorder** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Blood Pressure (high or low)** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Bone/Joint Problems** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Cancer** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Cirrhosis/Liver Disease** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Diabetes** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Epilepsy/Seizures** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Eye Disease/Blindness** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Fibromyalgia/Muscle Pain** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Glaucoma** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Headaches** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Head injury/Brain Trauma** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Hearing problems/deafness** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Heart disease** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Hepatitis/jaundice** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Kidney disease** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Lung disease** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Menstrual pain** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Oral health/dental** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Stomach/bowel problems** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Stroke** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Thyroid** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Tuberculosis** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **HIV/AIDS** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Sexually transmitted disease** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Learning problems** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Speech problems** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Anxiety** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Bipolar** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Depression** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Eating Disorder** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Hyperactivity/ADD** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Schizophrenia** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Sexual problems** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Sleep Disorder** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |

| Client Name: | | | | | | |
|---|---|---|---|---|---|---|
| **Suicidal thoughts/attempts** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Other:** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Other:** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |
| **Other:** | ☐ Now | ☐ Past | ☐ Never | Family History? | ☐ Yes | ☐ No |

**If you marked 'Now' or 'Past' above, please describe treatment for the condition:**

**Have you had any of the following symptoms in the past 60 days:**

☐ Ankle swelling
☐ Bed-wetting
☐ Blood in stool
☐ Breathing difficulty
☐ Chest pain
☐ Confusion
☐ Consciousness loss
☐ Constipation
☐ Coughing
☐ Cramps
☐ Diarrhea
☐ Dizziness
☐ Falling
☐ Gait unsteady
☐ Hair Change
☐ Hearing loss
☐ Lightheadedness
☐ Memory problems
☐ Mole/wart change
☐ Muscle weakness
☐ Nervousness
☐ Nosebleeds
☐ Numbness
☐ Panic attacks
☐ Penile discharge
☐ Pulse irregularity
☐ Seizures
☐ Shakiness
☐ Sleep problems
☐ Sweats (night
☐ Tingling in arms/legs
☐ Tremor
☐ Urination difficulty
☐ Vaginal discharge
☐ Vision change
☐ Vomiting
☐ Other (Specify):
☐ Other (Specify):
☐ Other (Specify):
☐ Other (Specify):

**Do you have allergies** ☐ Yes ☐ No

**If yes, what are you allergic to?**

**What happens to you?**

**Medications (Please include all medications, herbal supplements, vitamins, etc.)**

| Medication Name | Date Started | Dosage | Comments |
|---|---|---|---|
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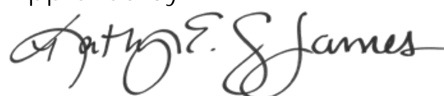
**Please check all immunizations you have received:** ☐ Chicken Pox ☐ Diphtheria

☐ German Measles ☐ Hepatitis B ☐ Measles ☐ Mumps ☐ Polio

☐ Small Pox ☐ Tetanus ☐ Other (Specify):

| Client Name: | | |
|---|---|---|
| List immunizations received within the past year: | | |
| **Pain Management** | | |
| Does pain currently interfere with your regular activities? ☐ Yes ☐ No<br>If yes, by how much? ☐ Extremely ☐ Severely ☐ Moderately ☐ Mildly ☐ Not at all<br>Please indicate the source of pain: | | |
| **Pregnancy Information** | | |
| Have you ever given birth to a child? ☐ Yes ☐ No #of births:<br>Within the past 5 years? ☐ Yes ☐ No<br>Birth Status: ☐ Live ☐ Stillborn ☐ Both live and stillborn<br>Are you currently pregnant? ☐ Yes ☐ No<br>If yes, what stage of pregnancy? ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester ☐ Unknown<br>Have you received prenatal care? ☐ Yes ☐ No<br>If yes, what week did it begin? | | |
| **Physical/Nutritional Information** | | |
| Height: Feet Inches | Weight: pounds | |
| Any significant change in your weight in the past year? ☐ Yes ☐ No | | |
| Please indicate any nutritional problems:<br>Eating: ☐ More ☐ Less ☐ Not Eating ☐ N/A<br>Drinking: ☐ More ☐ Less ☐ Not Eating ☐ N/A<br>Appetite: ☐ More ☐ Less ☐ Not Eating ☐ N/A<br>Other Nutritional Problems: ☐ Nausea ☐ Trouble Chewing ☐ Swallowing ☐Vomiting | | |
| Special Diet: | | |
| **Primary Care Physician** | | |
| Do you have Primary Care Provider (PCP)? ☐ Yes ☐ No | | |
| PCP Name: | Phone Number: | Fax Number: |
| Street Address: | City: | State: |
| County: | Zip Code: | |
| What was the date of your last appointment? | | |

Origination: 05/14
Effective: 03/24/20
Approved by:



Kathryn E. St. James, President & CEO
Behavioral Healthcare Partners of Central Ohio, Inc.

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