# Healing Day Counseling&Psychotherapy

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## Bio-Psycho-Social Information

First Name:

Last Name:

Date of Birth:

Address:

1. Presenting Problem: _____

_____

2. Education (grade Completed): _____

3. Legal History: _____

4. Military History: _____

5. How would you rate your current physical health?

Poor ▫ Unsatisfactory ▫ Satisfactory ▫ Good ▫ Very good ▫

Please list any specific health problems you are currently experiencing:

_____

6. How would you rate your current sleeping habits? (please circle)
Poor ▫ Unsatisfactory ▫ Satisfactory ▫ Good ▫ Very good ▫

Please list any specific sleep problems you are currently experiencing:_____

_____

7. Do you Exercise? Yes ▫ No ▫

If yes, how often do you exercise?

Type of the exercise:

8. Please list any difficulties you experience with your appetite or eating patterns:

_____
_____

9. Are you currently experiencing overwhelming sadness, grief or depression?

No ▫ Yes ▫

If yes, for approximately how long? _____

10. Are you currently experiencing anxiety, panic attacks or have any phobias?

No ▫ Yes ▫

If yes, when did you begin experiencing this? _____

11. Are you currently experiencing any chronic pain?

No ▫ Yes ▫

If yes, please describe _____

13. Do you drink alcohol more than once a week? No ▫ Yes ▫

12. How often do you engage recreational drug use?

Daily ▫ Weekly ▫ Monthly ▫ Never ▫

13. Do you use tobacco? Yes ▫ No ▫

if yes, what type and how much?

14. Are you currently in a romantic relationship?

No ▫ Yes ▫
If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

15. What significant life changes or stressful events have you experienced recently:

_____

**FAMILY MENTAL HEALTH HISTORY:**

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse Anxiety: _____
Depression:_____

Domestic Violence:_____

Eating Disorders: _____

Obesity: _____

Obsessive Compulsive Behavior Schizophrenia:
_____

Suicide Attempts: _____

**Current Family/SocialRelationship, Sexual Orientation:**

Sexual Orientation: _____ Current Relationship Status:_____ With Whom do you live_____ Is alcohol and drug present where you live? _____ If yes, Who is using? _____ Do you have Children? _____ If yes, how many Children do you have? _____ Do they live with you? _____

Familiy History ( Where were you born, Who raised you and where were you raised? Do you have siblings, if yes how many? Is there any history of any kind of abuse in the family?)

_____

_____

_____