

Health Assessment Form

Client Information				
First Name	Last Name	Preferred Name	Patient Identifier (If known)	
Gender	Preferred Pronouns	Date of Birth	Marital Status	
Address		City	State	Zip Code
Email		Preferred Phone Number		
Physical Health				
Weight	Usual Weight	Height	BMI	
Medical History				
Current Medical Condition				
Describe your sleeping patterns (How many hours of sleep each night, wake up time, sleep time)				
Do you face any challenges with your sleeping patterns? If yes, please specify.				
How often do you exercise?				
Are there any concerns with your eating habits? If yes, please specify.				
Are you a smoker? If yes, please specify.				
Is there any other physical health information you would like to disclose?				

Client Information			
First Name	Last Name	Date of Birth	Gender
Psychological and Social Health			
Do you have a past/present mental health diagnosis? If yes, please specify			
Please select any of the following symptoms that you have			
<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Suspiciousness	<input type="checkbox"/> Crying Spells	
<input type="checkbox"/> Excessive Worry	<input type="checkbox"/> Excessive Energy	<input type="checkbox"/> Loss of Interest	
<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Increased Irritability	<input type="checkbox"/> Hallucinations	
<input type="checkbox"/> Sleep Pattern Disturbance	<input type="checkbox"/> Increased Risky Behaviors	<input type="checkbox"/> Decreased need of sleep	
<input type="checkbox"/> Avoidance	<input type="checkbox"/> Racing Thoughts	<input type="checkbox"/> Change in Appetite	
<input type="checkbox"/> increased Libido	<input type="checkbox"/> Unable to Enjoy Activities	<input type="checkbox"/> Excessive Guilt	
<input type="checkbox"/> Concentration/Forgetfulness	<input type="checkbox"/> Anxiety Attacks	<input type="checkbox"/> Fatigue	
<input type="checkbox"/> Decreased Libido	<input type="checkbox"/> Other:		
How would you describe your relationship with family and friends?			
Rate your current stress level from 1(best) to 5(worst)		Rate your current happiness level from 1(best) to 5(worst)	
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 1	<input type="checkbox"/> 2
<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<input type="checkbox"/> 5		<input type="checkbox"/> 5	
Educational and Employment Health			
<input type="checkbox"/> Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____			
Occupation	Industry	Company Name	
Company Address	City	State	Zip Code
Are there any personal career growth concerns? If yes, please specify			
Clinician Name	Clinician Designation	Clinician Signature	Date
			