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

- ☐ Depressed Mood
- ☐ Excessive Worry
- ☐ Impulsivity
- ☐ Sleep Pattern Disturbance
- ☐ Avoidance
- ☐ increased Libido
- ☐ Concentration/Forgetfulness
- ☐ Decreased Libido
- ☐ Suspiciousness
- ☐ Excessive Energy
- ☐ Increased Irritability
- ☐ Increased Risky Behaviors
- ☐ Racing Thoughts
- ☐ Unable to Enjoy Activities
- ☐ Anxiety Attacks
- ☐ Other:
- ☐ Crying Spells
- ☐ Loss of Interest
- ☐ Hallucinations
- ☐ Decreased need of sleep
- ☐ Change in Appetite
- ☐ Excessive Guilt
- ☐ Fatigue

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)
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Educational and Employment Health

◯ Employed ◯ Self Employed ◯ Unemployed ◯ 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