TAMPA COUNSELING AND WELLNESS

Health Information Form:

Name: _____ Todays Date: _____/_____/_____

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Sexual Orientation: _____ Relationship Status: _____

Race: _____ Ethnicity: _____

Religion: _____ Languages: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Voice Message OK: □Yes□No Text Message OK: □Yes□No

Email: _____

Would you like to receive appointment reminders via email? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication. :

EMERGENCY CONTACT: _____ Relationship:

Phone Number: (_____) _____-_____

CURRENT ISSUE:

Reason for seeking services:

_____

_____

_____

When did the issue(s) and/or symptoms begin? _____

What caused/contributed to your issue(s) and/or symptoms?

_____

_____

_____

Have you received mental health services in the past? □No □Yes

If yes, please provide:

Name of provider or facility: _____

Location (city/state): _____

Length of treatment:
_____

Reason for treatment: _____

MEDICAL/HEALTH HISTORY

Name of primary care physician/doctor: _____

Address: _____ Phone: _____

Please list any health problems you are currently experiencing or have been diagnosed with in the past:

_____
_____
_____

Please list medication you are currently taking:

Medication	Dosage	Condition/Reason

How many times per week do you exercise? _____ Type:_____

How much caffeine do you consume daily? _____ Type: _____

Please describe any past or current **alcohol/drug** use:

_____
_____

Please describe any past/current **legal issues**:

_____
_____

Education:

Highest grade completed: _____ Degree type: _____

Major(s): _____

Career/Occupation:

Current Occupation: Title:

Employer: Years:

DEVELOPMENTAL HISTORY

Did you experience any of the following? ☐Premature pregnancy ☐Slow to Walk ☐Slow to talk

▫ Low birth weight ▫ Trouble toilet training ▫ Bedwetting

What do you consider to be some of your strengths?

_____

_____

What do you consider to be some of your limitations?

_____

_____

_____

Printed Name

_____

Client Signature **OR**

_____

Printed Name

_____

Legal Guardian Signature

_____

Date