SNAHC
Sacramento Native American Health Center
a california health center

_____
Patient Name (Last, First, MI)

_____
Date of Birth

_____
HRN

Gender Identity ☐ **M** ☐ **Transgender M**
☐ **F** ☐ **Transgender F**

Behavioral Health/Substance Use Treatment Health History (ages 18 and up)

Note: This information is confidential and will be reviewed by the provider. The information will be used to connect you with appropriate services.

GENERAL INFORMATION

On a scale of 0-10, with 10 being excellent, please rate how you feel.

1 2 3 4 5 6 7 8 9 10

Yes No

☐ ☐ Have you ever been in counseling before?
☐ ☐ Are you a survivor of physical or emotional trauma?
☐ ☐ To the best of your knowledge, did you meet major milestones on time? (Walking, talking, toilet training, etc.)
☐ ☐ As a minor, were you ever placed outside of your parent's home? (Foster care, boarding school, juvenile hall, etc.)
☐ ☐ Have you ever been arrested?
☐ ☐ Do you currently have legal involvement (court case, lawsuit, child custody, parole or probation)?
☐ ☐ Are you currently employed?
How many years were you employed at your current or most recent employment? _____

What is your highest level of education?
☐ Some high school ☐ High school diploma ☐ Some college ☐ Bachelors ☐ Graduate

What is your relationship status? What has it previously been?
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnered Other_____

How many children do you have? _____

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Revised 3/31/2017

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MEDICATIONS AND SUBSTANCE USE

Are you taking or have you taken any of the following in the last three months?

Yes No

- ☐ ☐ More than 1 or 2 alcohol drinks/day
- ☐ ☐ Recreational drugs
- ☐ ☐ Weight loss medications
- ☐ ☐ Tobacco in any form

Yes No

- ☐ ☐ Psychiatric medications
- ☐ ☐ Herbal remedies/programs
- ☐ ☐ Over – the – counter medicines

- ☐ ☐ Would you say you have ever used "self-medication" to deal with problems?
- ☐ ☐ Have you had previous treatment for alcoholism or drug dependency?

HEALTH HISTORY

Do you currently experience or have you experience any of the following?

Yes No

- ☐ ☐ Diabetes
- ☐ ☐ Hepatitis
- ☐ ☐ Hearing or seeing things other people do not
- ☐ ☐ Indecisiveness/ impulsivity
- ☐ ☐ Isolation/loneliness
- ☐ ☐ Loss of memory or time
- ☐ ☐ Feelings that life is empty/ hopeless/unenjoyable
- ☐ ☐ Angry outbursts/temper
- ☐ ☐ Poor concentration

Yes No

- ☐ ☐ Felt tense / anxious/ unable to relax
- ☐ ☐ Eating disorder
- ☐ ☐ Panic attacks or phobias
- ☐ ☐ Repetitive thoughts or behaviors
- ☐ ☐ Sexual/gender identity issues, or sexual /gender concerns
- ☐ ☐ Problems with relationships
- ☐ ☐ Financial problems

Yes No

- ☐ ☐ Currently having thoughts of hurting yourself or others
- ☐ ☐ Trouble sleeping
- ☐ ☐ Paranoia
- ☐ ☐ Loss of appetite or increased appetite
- ☐ ☐ Unusual increase or decrease in activity or energy for days

Have any of your family members had any of the following conditions?

Yes No

- ☐ ☐ Mental/Emotional problems
- ☐ ☐ Alcohol/Drug problems

Name _____ DOB _____ HRN _____

SERVICES NEEDED

Yes No

☐ ☐ Do you have any physical health conditions that impact your daily functioning? If yes, please describe. _____

Do you need assistance for the following daily activities?

☐ Cooking
☐ Grocery shopping
☐ Getting to appointments
☐ Dressing
☐ Using the toilet
☐ Taking medications
☐ Taking medications by injection

Yes No

☐ ☐ Would you like to meet with a mental /behavioral health therapist?
If Yes, What are you hoping to accomplish in counseling?_____

☐ ☐ Would you like to meet with a domestic violence counselor?

☐ ☐ Would you like to meet with a drug or alcohol counselor?

☐ ☐ Would you like to see a medical doctor to address physical health concerns?

The above information is true and accurate to the best of my recollection.

PLEASE REMEMBER THAT AT THIS TIME SNAHC IS NOT TAKING CHRONIC PAIN PATIENTS (i.e. "No refills for Narcotic Pain Medications such as Norco, Vicodin, Oxycontin, etc)

Patient Signature: _____ Date: _____

Provider Name: _____Signature: _____ Review Date:_____