Beloit Health System 1969 West Hart Road – Beloit, Wisconsin 53511 (608) 364-5686 PHONE (608) 364-5756 **COUNSELING CARE CENTER**	Today's Date: Name:

Client Self-Reported History – Page 1 of 4

Below are a number of questions about you and your health history. This information will be helpful to our staff in assessing and planning treatment for you. Please check a response for each question/item. Feel free to discuss these with our staff.
All information you provide here is confidential. Thank you.

DEMOGRAPHIC *(check one answer or fill in the blank)*

1. Gender? ☐Male ☐Female ☐Other _____ 2. Date of Birth _____/_____/_____
3. What is your Status? ☐Married ☐Widowed ☐Separated ☐Divorced ☐Never Married ☐Long Term Partnership
4. How far did you go in school? ☐8th grade or less ☐some high school (HS) ☐HS graduate or equivalent (GED)
   ☐ some college or associate degree ☐ college graduate
5. How many children do you have? _____ 6. How many children live in your home? _____
7. Military? ☐No ☐Yes If so, what branch? _____ Active? _____
8. Religious affiliation? _____ Actively Involved? ☐Yes ☐No

MEDICATIONS

9. Please list the names of all medications that you are now taking, including prescribed, over-the-counter, herbals/vitamins, and as-needed medications:
   Prescribed: _____
   _____
   _____
   Other: _____
   _____
10. Have you ever had an allergic or other bad reaction to any medications or foods? (*Check one)* ☐ No ☐ Yes
    If yes, please explain _____

The following questions will help us assess your health history. Please mark an X in the Yes or No box to the right for each question below, answering to your best knowledge.

Please list your physician(s) names: _____

Rate any pain you experience from 1 to 10, with 10 being completely unbearable _____ Where is the pain? _____

HABITS

1. Have you ever smoked cigarettes, cigars or a pipe? …… Yes ☐ No ☐
2. How many days in the past month have you smoked cigarettes, cigars or a pipe? …… _____ days
3. What is the average total number of cups or cans of coffee, tea or caffeinated sodas (cola, Mountain Dew, Dr. Pepper) that you drink in a typical day? …… ____cups & cans
4. Approximately how many days have you had beer, wine, or liquor to drink in the past 30 days? …… _____ days
5. On days when you did drink, what is the average total number of drinks you had? *(one drink = one 12 oz. Beer, or one shot of spirits, or one 4 oz. Glass of wine)* …… _____ drinks
6. In the past month, did you ever have 5 or more drinks in a single day? ……Yes ☐ No ☐
7. Approximately how many days have you used amphetamines, cocaine, crack, marijuana, sleeping pills, Valium or

other sedatives in the past 30 days? …… _____ days

HABITS - Continued

8. Have you ever felt you should cut down your drinking of alcohol? …… Yes ☐ No ☐
9. Have you ever been annoyed by complaints about your drinking? …… Yes ☐ No ☐
10. Have you ever felt guilty or upset about your drinking? …… Yes ☐ No ☐
11. Have you ever had a drink in order to feel better in the morning? …… Yes ☐ No ☐
12. Have you ever had professional counseling about your drinking or drug use? …… Yes ☐ No ☐

EMOTIONAL PROBLEMS

1. Have you ever had a panic attack, when you suddenly feel frightened, anxious or extremely uncomfortable? ……. Yes ☐ No ☐
2. Do you often feel very uncomfortable being watched or noticed by other people (such as when you speak to someone in public, write in a public place, or eat in public) because you feel you will do something embarrassing or humiliating? ……. Yes ☐ No ☐
3. Are there things that you have been especially afraid of like flying, heights, seeing blood, closed places, bridges or certain kinds of animals or insects? …… Yes ☐ No ☐
4. Are you often bothered by thoughts that make you anxious, seem senseless and that you cannot get rid of, even when you try to resist having them? …… Yes ☐ No ☐
5. Have you ever had things that you had to do over and over again and couldn't resist doing (like washing your hands again and again, or checking something several times to make sure you'd done it right) more than most other people you know? …… Yes ☐ No ☐

In the **past six months**, have you had a lot of difficulty with:

6. Controlling your "nerves" or feeling anxious and on the edge? …… Yes ☐ No ☐
7. Worrying excessively about many different things on most days? …… Yes ☐ No ☐

In the **past three months**, have you had:

8. Several eating binges in which you ate very large amounts of food in a short amount of time? …… Yes ☐ No ☐
9. A feeling your eating was out of control? …… Yes ☐ No ☐

In **your lifetime**, have you ever had a period that lasted **at least two weeks** when, most of the day, every day, you felt:

10. Little interest or pleasure in doing things? …… Yes ☐ No ☐
11. Down, sad, depressed or hopeless? …… Yes ☐ No ☐

In the **past two weeks**, have you been bothered most of the day, every day, by:

12. Feeling little interest or pleasure in doing things? …… Yes ☐ No ☐
13. Feeling down, sad, depressed, or hopeless? …… Yes ☐ No ☐
14. Have you **ever in your life** had a period lasting **a week or more** when you were feeling so good or hyper that other people that that you were not your normal self, or you were so irritable that you would shout at people or start fights or arguments? …… Yes ☐ No ☐
15. Has a counselor or doctor ever told you that you had bipolar disorder or a manic episode? …… Yes ☐ No ☐
16. Have you ever felt that people were talking about you behind your back or taking special notice of you? …… Yes ☐ No ☐
17. Have you ever felt that anyone was going out of the way to give you a hard time, attack, cheat or try to hurt you? Yes ☐ No ☐
18. Have you ever felt that you were especially important in some way, or that you had powers to do things that normal people couldn't do? …… Yes ☐ No ☐
19. Have you ever felt that someone or something outside yourself was controlling your thoughts or actions against your will? …… Yes ☐ No ☐
20. Have you ever felt that your thoughts were being broadcast out loud so that other people could actually hear what you were thinking? …… Yes ☐ No ☐
21. Have you ever heard things that other people could not hear, such as noises or the voices of people talking or whispering? …… Yes ☐ No ☐

22. Have you ever had visions or seen things that others couldn't see? ..... Yes ☐ No ☐

23. Have you ever intentionally overdosed, physically injured yourself or attempted suicide? ..... Yes ☐ No ☐

EMOTIONAL PROBLEMS - Continued

24. Have you ever injured another person accidentally or intentionally? ..... Yes ☐ No ☐

25. Have you ever been arrested, charged with a crime or do you have any legal concerns? ..... Yes ☐ No ☐

26. Are you experiencing suicidal/homicidal feelings/thoughts? ..... Yes ☐ No ☐

27. What do you do for leisure? _____

28. Has your interest in this changed? ..... Yes ☐ No ☐

MENTAL HEALTH TREATMENT

Have you ever seen a counselor, psychologist, psychiatrist or other mental health specialist for help with a problem before today?

No ☐ Yes ☐ If yes, please tell us when, where and why you sought treatment:

Year/Date Place Reason/Diagnosis

_____

_____

_____

PSYCHIATRIC HOSPITALIZATIONS

Have you ever been hospitalized for psychiatric treatment?

No ☐ Yes ☐ If yes, please tell us when, where and why you were hospitalized:

Year/Date Place Reason/Diagnosis

_____

_____

_____

MEDICAL HOSPITALIZATIONS

Have you ever had an overnight hospital stay or ambulatory surgery for treatment of a problem other than mental health problems? ☐ No

☐ Yes If yes, please indicate when, where and why:

Year/Date Place Reason/Diagnosis

_____

_____

_____

NEUROLOGICAL

1. Have you ever had a seizure? (convulsion, epilepsy)..... Yes ☐ No ☐
2. Do you have frequent headaches? ..... Yes ☐ No ☐
3. Have you had problems with coordination or weakness? ..... Yes ☐ No ☐
4. Problems with tingling or numbness of your hands or feet? ..... Yes ☐ No ☐
5. Have you ever had a serious head injury or been comatose? ..... Yes ☐ No ☐

CIRCULATORY - Have you ever had significant amounts of:

1. Swelling of your hands or feet? ..... Yes ☐ No ☐
2. Bad circulation, leg pain when walking or varicose veins? ..... Yes ☐ No ☐
3. Fainting Spells ..... Yes ☐ No ☐
4. Dizziness, lightheadedness, or fainting spells? ..... Yes ☐ No ☐

CIRCULATORY – Have you ever had significant amounts of:

5. High blood pressure? ..... Yes ☐ No ☐
6. Chest pain? ..... Yes ☐ No ☐

7. Palpitations or heart pounding? ..... Yes ☐ No ☐
8. Have you ever had a heart attack? ..... Yes ☐ No ☐

CIRCULATORY – Continued… Have you ever had significant amounts of:

9. Have you ever had an abnormal heart rhythm? ..... Yes ☐ No ☐
10. Have you ever had a heart murmur? ..... Yes ☐ No ☐
11. Have you ever had rheumatic fever? ..... Yes ☐ No ☐

RESPIRATORY – Have you ever had:

1. Shortness of breath after minor exercise, asthma, or emphysema? ..... Yes ☐ No ☐
2. Tuberculosis or a positive TB skin test? ..... Yes ☐ No ☐
3. Pneumonia, chronic bronchitis, or frequent sinusitis? ..... Yes ☐ No ☐

URINARY

1. Have you ever been told that you have kidney disease? ..... Yes ☐ No ☐
2. Have you ever had kidney stones? ..... Yes ☐ No ☐
3. Have you ever had a urinary tract (bladder) infection? ..... Yes ☐ No ☐
4. Do you ever notice blood in your urine? ..... Yes ☐ No ☐

GASTROINTESTINAL

1. Have you lost or gained more than 5 lbs. in the past 6 months? ..... Yes ☐ No ☐
2. Do you have any pain or difficulty when swallowing? ..... Yes ☐ No ☐
3. Have you ever had significant heartburn? ..... Yes ☐ No ☐
4. Have you ever had an ulcer? ..... Yes ☐ No ☐
5. Have you ever had black or bloody bowel movements? ..... Yes ☐ No ☐
6. Have you ever had hepatitis or other liver disease? ..... Yes ☐ No ☐
7. Have you ever been told that you had pancreatitis? ..... Yes ☐ No ☐
8. In the **past month**, have you had significant amounts of:

Nausea	Yes ☐	No ☐	Diarrhea	Yes ☐	No ☐
Vomiting	Yes ☐	No ☐	Constipation	Yes ☐	No ☐

ENDOCRINE

1. Have you ever been told you have diabetes? ..... Yes ☐ No ☐
2. Have you ever been told you have thyroid disease? ..... Yes ☐ No ☐

REPRODUCTIVE - FEMALE

1. Have you had a tubal ligation or hysterectomy? ..... Yes ☐ No ☐
2. Have you ever had abnormal PAP tests or uterine/cervical cancer? ..... Yes ☐ No ☐
3. Have you gone through menopause? ..... Yes ☐ No ☐

REPRODUCTIVE – MALE

1. Have you ever had problems with impotence? ..... Yes ☐ No ☐

OTHER

1. Have you ever had anemia? ..... Yes ☐ No ☐
2. Have you ever had cancer? ..... Yes ☐ No ☐
3. Have you ever had psoriasis or other serious skin disease? ..... Yes ☐ No ☐
4. Have you ever had arthritis, gout, or other joint disease? ..... Yes ☐ No ☐

Patient Signature _____ Date _____

Patient Printed Name _____ Revised 8/26/2021