Life Coast Community Health Center
Behavioral Health Adult Client Questionnaire

Date: ____________________

NAME: ________________________________ SOCIAL SECURITY #: ________________________ DOB: ______________

RACE: ____________________ SEX: □ MALE □ FEMALE GENDER IDENTITY: ____________________________

ADDRESS: ______________________________ CITY: _______________ ZIP CODE: ____________ PARISH: _____________

PRIMARY PHONE: ___________________ WORK PHONE: ____________________ EMAIL: _______________________

MARITAL STATUS: □ Single □ Married □ Separated □ Divorced □ Widowed

U.S. CITIZEN □ YES □ NO | **VETERAN** □ YES □ NO | **DISABLED** □ YES □ NO

DO YOU HAVE CHILDREN UNDER THE AGE OF 18 LIVING WITH YOU? □ YES □ NO: AGES: ______________________

DO YOU HAVE A PRIMARY CARE PHYSICIAN (PCP)? □ YES (PCP'S NAME: ___________________________________) □ NO

CURRENT TREATMENT: ARE YOU RECEIVING ANY MENTAL HEALTH/SUBSTANCE ABUSE SERVICES NOW? □ NO □ YES (IF YES, WHERE?)

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CHECK ONLY ONE:

□ I HAVE SIGNED AN AUTHORIZATION TO RECEIVE/RELEASE PROTECTED HEALTH INFORMATION (PHI) (PT'S INITIALS ____________)

□ I HAVE SIGNED A REFUSAL/REVOCATION OF AUTHORIZATION TO RECEIVE/RELEASE PHI (PT'S INITIALS ______________)

Mental Health/Substance Abuse Treatment History:

Have you ever been treated by (check all that apply) □ Psychiatrist □ Psychologist □ Counselor □ Social Worker □ PCP?

Check all that apply (describe who provided treatment, dates of treatment, name, and location of facility):

- □ Outpatient treatment ____
- □ Inpatient treatment ____
- □ Residential treatment ____

Have you ever been diagnosed with any of the following conditions (check all that apply)?

□ Generalized Anxiety Disorder □ Obsessive-Compulsive Disorder (OCD) □ Depression □ Anorexia □ Schizophrenia

□ Panic Attacks □ Post-Traumatic Stress Disorder (PTSD) □ Bipolar Disorder □ Bulimia □ Autism/Developmental Disorder

□ List any other Mental Health problems you've had (past or present) ______________________________

Please write a brief statement about why you want to be seen by a mental health provider (include if you've been told by another provider or agency to come here)

Medication Summary: Please list all medications you have been prescribed (attach a separate sheet if needed)

□ **Medication Allergies** ____

Current Medication (Currently Taking)	Dose		Past Medication (no longer taking)	Dose

Client Name: ______________________________________ DOB: ____________________________

MEDICAL HISTORY (Check any that apply for current or past)

□ Surgeries	□ Asthma	□ Heart Problems	□ Diabetes	□ Other ________________
□ Vision problems	□ Hearing problems	□ Seizures	□ Stomach Problems	______________________
□ Serious Injuries	□ Head Injuries	□ Lung problems	□ Liver problems	□ Food allergies ___________
□ Kidney problems	□ Neurological Problems	□ Tuberculosis	□ HIV	□ STDs

EDUCATIONAL HISTORY Highest grade/degree completed ____

School Problems: □ None □ Learning Problems □ Failed Classes □ Conduct Problems
□ Suspension / Expulsion □ Special Education □ YES □ NO

Do you want to return to school or get special training? □ YES ______________________________________ □ NO

SKILLS – INTERESTS - HOBBIES

A. What kind of activities/ hobbies do you enjoy?

B. How often do you get to do these activities?

C. What prevents you from doing these activities?

RELIGION / CULTURAL

A. Does spirituality or religion help you cope?	□ YES □ NO		**D**. Do you attend religious services?	□ YES □ NO
B. Do you belong to a religious community?	□ YES □ NO		**E**. Is suicide against your beliefs?	□ YES □ NO
C. Do you meditate or pray?	□ YES □ NO		**F**. Do you want to be more spiritual?	□ YES □ NO

LEGAL STATUS/HISTORY:

A. Have you ever been Arrested? □YES □NO **B**. Ever been in jail? □YES □NO **C**. Currently on probation/parole? □YES □NO

Types of Charges: ____

FINANCIAL/TRANSPORTATION

A. Housing Situation: □ Permanent □ Temporary □ Homeless

B. Living Conditions (check all that apply): □ Safe □ Unsafe □ Unclean □ Crowded □ Needs repair

C. In your neighborhood is there: □ Violence □ Crime □ Drugs □ Unsafe Conditions

D. Do you have running water?	□ YES □ NO		**H**. Do you have electricity?	□ YES □ NO
E. Do you have cooling and heating?	□ YES □ NO		**I**. Do you have adequate food?	□ YES □ NO
F. Can you get medical treatment if needed?	□ YES □ NO		**J**. Can you afford needed medication?	□ YES □ NO
G. Do you have reliable transportation?	□ YES □ NO		**K**. Are you able to care for dependents	□ YES □ NO

How do you usually travel? □ Personal vehicle □ Family/Friends □ Medicaid transportation □ Council on Aging □ Other _______

FAMILY HISTORY Do any close relatives have any of the following: (check all that apply)

□ Depression □ Anxiety □ Bipolar Disorder □ Schizophrenia □ Alcohol or drug abuse problems □ Other Serious Mental Illness

Describe: ____