Forward Motion Coaching & Consulting Layne Hood, CPC, LCSW, 541.390.5373

Basic Client History (Rev: 10012014) Name: _____ FM Case#: _____

Briefly summarize what you want from this service:

_____

_____

Please circle "Yes" or "No" and write in the blanks to complete your answers to the following items.

1. (Yes No) I have a primary physician. [Dr's Name: _____] 2. Date of last Physician Visit: ___/___/_____

3. (Yes No) I was referred by my physician. 4. Last Complete Physical Exam: ___/___/_____

5. (Yes No) I have allergies [To what? _____]

6. (Yes No) I have been diagnosed with a substance use problem. [Which? _____]

7. (Yes No) I have been diagnosed with a nervous, emotional, or mental condition. [Which? _____]

9. (Yes No) I have other medical condition(s). [Which? _____]

8. (Yes No) I use prescribed medication(s). [Which? _____]

To answer the following please circle "yes" or "no" &/or the provided "1 (lesser) to 5 (greater)" rating. If you cannot or do not wish to answer, just circle N/A. Please add brief notes on your "history" where asked.

9. (Yes No or N/A) I have had behavioral/mental health treatment before.
   History of counseling? _____
   History of medication? _____
10. (Yes No or N/A) I use alcohol or other drugs. (If so: I prefer ___ alcohol or ___ other drugs)
   History of habitual alcohol use? _____
   History of alcohol abuse treatment? _____
   History of other drugs use? _____
   History of drug abuse treatment? _____
11. (Yes No or N/A) I use tobacco. (If so, form? _____ amount? _____)
   History of habitual tobacco use? _____
12. (Yes No or N/A) History of depression? _____
   _____
13. (Yes No or N/A) History of anxiety? _____
   _____
14. (Yes No or N/A) I feel like hurting or killing myself. (If so, which: ___ hurting, ___ killing)
   (Yes No or N/A) I have hurt myself or tried to kill myself.
   History of such feelings or actions? _____
15. (Yes No or N/A) I get angry. (If so: I ___ lash out or ___ withdraw?)
   History of hurting anyone? _____
16. (Yes No or N/A) I struggle to focus. If yes: Duration? _____ Severity? Less (1 2 3 4 5) More
   History of trouble focusing? _____
17. (Yes No or N/A) I see or hear things others don't. If yes: Duration? _____ Severity? Less (1 2 3 4 5) More
   History of seeing or hearing things? _____
18. I rate the amount & quality of my sleep as: Less (1 2 3 4 5) More ; (N/A)
   History of sleep pattern? _____
19. I rate the regularity of my eating & my attention to nutrition as: Less (1 2 3 4 5) More ; (N/A)
   History of eating habits? _____
20. I rate the amount & quality of my exercise as: Less (1 2 3 4 5) More ; (N/A)
   History of exercise habits? _____
21. Right now my height is _____ and my weight is _____ N/A
   History of weight changes? _____