MONARCH COUNSELING

Client Name: ________________________ **Date:**_____________

Presenting Issue:

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Past/Present Mental Health Providers:

Name:______________________________ Phone:____________________ Dates:________________

Name:______________________________ Phone:____________________ Dates:________________

Past Diagnoses: ____

Past Treatments and/or Hospitalizations: ____

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Past/Present Medical Providers (e.g. Primary Care Physicians:

Name:______________________________ Phone:____________________ Dates:________________

Name:______________________________ Phone:____________________ Dates:________________

Medical Conditions/History:____

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Current Medications: ____

Allergies: Yes □ No □ If yes, what are the allergies and reactions?

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Can we contact your:

Psychiatrist: Yes □ No □

Medical Doctor: Yes □ No □

Contact info for other providers:

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Do you have psychiatric advance directives? Yes □ No □ If yes, please provide a copy.

If no, Would like information on psychiatric advance directives. Yes □ No □

Do you or have you ever done harmful behavior to self or others? Yes □ No □

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Do you currently or have you ever had problems with alcohol, drugs, or missuses of prescription medications? Yes □ No □ If yes, please explain further below.

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Do you use anything containing nicotine? Ex: Cigarettes, E- cigarettes, chewing tobacco, snuff, cigars. Yes □ No □ If yes, please explain further below.

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Would you like to quit your nicotine use? Yes □ No □

Have you used or heard of the Nebraska quit line 1-800-QUIT-NOW (1-800-784-8669)? Yes □ No □

Are you presently involved in the legal system? Ex: Parole, Probation, CPS, DHHS, Diversion etc.

Family History:

Has anyone if your family been diagnosed with a mental illness? If so, What was it?

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Has anyone in your family been diagnosed with a medical illness? If so, What was it?

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Has anyone in your family struggled with substance abuse? If so, Which substances and how often?

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