ODYSSEY WELLNESS

9183 W. Flamingo Road, Suite 100
Las Vegas, NV 89147
O: 702.907.6521
F: 702.710.6521

PSYCHOSOCIAL AND CLINICAL HISTORY
Adult

Contact Information:

Name of the client _____ DOB _____
(First) (Middle) (Last)

Date of Birth: _____ Age: _____

Address: _____

City _____ State _____ Zip_____

Preferred Phone Number: _____ Type: Home Cell Work Other

Secondary Phone Number: _____ Type: Home Cell Work Other

Email: _____

Is it okay to send email? Yes ☐ No ☐
Is it okay to leave messages? Yes ☐ No ☐
Is it okay to text appointment reminders? Yes ☐ No ☐

Referral Source _____

Demographic Information: (Please answer to the extent you are comfortable.)

Place of Birth: _____ Ethnicity:_____
Gender: _____ Sexual Orientation: _____

Relationship Status:

___ Single ___ Married/Partnered ___ Divorced ___ Other (see below)

___ Living w/ Partner ___ Separated ___Widowed _____

Who currently lives with you in your home: (Please use back of paper if additional space is needed.)

Name:_____ Relationship:_____ Age:_____

Name:_____ Relationship:_____ Age:_____

Name:_____ Relationship:_____ Age:_____

Name:_____ Relationship:_____ Age:_____

Highest level of education completed (8th grade, MS degree, etc.)_____

What is your current occupation?_____

Are you a parent? Yes ☐ No ☐
Are you currently in the branch of the military? Yes ☐ No ☐
Are you a veteran? Yes ☐ No ☐
Are you a college student? Yes ☐ No ☐
Do you currently have a diagnosed disability? Yes ☐ No ☐

Have you or any of your biological (blood) relatives have or been treated for any of the below (Please check all that apply below and state which member of your family)?

- ☐ Anxiety _____
- ☐ Anger control problems _____
- ☐ Learning Disorder _____
- ☐ Autism Spectrum _____
- ☐ Mental Disability _____
- ☐ Phobias _____
- ☐ Alcohol Abuse _____
- ☐ Seizure _____
- ☐ Other _____

- ☐ Depression _____
- ☐ Attention Deficit Hyperactivity Disorder _____
- ☐ Bipolar Disorder _____
- ☐ Depression _____
- ☐ Sleep Disorder _____
- ☐ Schizophrenia _____
- ☐ Substance Abuse _____
- ☐ Genetic Disorder _____
- ☐ Other _____

Has any family member ever attempted or completed suicide and if so who? _____

_____

General Health History:

How would you describe your physical health? Poor ☐ Fair ☐ Good ☐ Excellent ☐

Describe any serious illnesses, injuries, or operations you've had and when it occurred:

_____

_____

Who is your doctor? _____ Date of last visit: _____

Reason for last visit: _____

Are you currently taking any medications for physical concerns? Yes ☐ No ☐

List of current medications:

_____

_____

Do you have problems with?

Allergies? Yes ☐ No ☐ Describe _____

Hearing? Yes ☐ No ☐ Describe _____

Vision? Yes ☐ No ☐ Describe _____

Do you exercise? Yes ☐ No ☐ Type/Frequency _____

Do you smoke? Yes ☐ No ☐ Type/Frequency _____

Do you drink alcohol? Yes ☐ No ☐ Type/Frequency _____

Do you use drugs? Yes ☐ No ☐ Type/Frequency _____

Do you consider your alcohol use a problem? _____

Do you consider your drug use a problem? _____

Presenting Concern(s):

Primary reason for seeking mental health services: _____

_____

_____

_____

_____

_____

Are you experiencing concerns with any of the following? Check all that apply.'

☐ General Anxiety	☐ Panic Attacks	☐ Depression
☐ Low Mood/Sadness/Depression	☐ Low energy/Fatigue	☐ Grief and/or Loss
☐ Lack of attention and focus	☐ Increased Energy	☐ Verbal Outbursts
☐ Academic Problems	☐ Irritability/Anger Problems	☐ Sleep Concerns
☐ Social Anxiety	☐ Physical altercations	☐ Phobia(s)
☐ Test Anxiety	☐ Relationship Concerns	☐ Life Transitions
☐ Easily Distracted	☐ Sexual Issues	☐ Lack of motivation
☐ Family Problems	☐ Difficulty making friends	☐ Eating Problems
☐ Difficulty communicating w/ others	☐ Problems keeping friends	☐ Impulsive Behavior
☐ Repetitive Behaviors	☐ Obsessive thoughts	☐ Intrusive thoughts
☐ Recent Sexual Assault	☐ Recent Physical Assault	☐ Nightmares
☐ Lack of interest in enjoyable activities	☐ Racing thoughts	☐ Employment
☐ Legal problems	☐ Increase alcohol use/abuse	☐ Drug abuse
☐ History of traumatic events	☐ Intrusive thoughts	☐ Feeling on edge
☐ Self-harm w/o suicidal ideation (SI)	☐ Recent Suicide Attempt	☐ Current SI

Other Symptoms Not Listed Above: _____

_____

_____

Are you currently experiencing suicidal thoughts? Yes ☐ No ☐

Have you ever purposefully injured yourself without suicidal intent? Yes ☐ No ☐

Have you ever made a suicide attempt? Yes ☐ No ☐

If yes, when?: _____

Are you currently having thoughts about harming someone? Yes ☐ No ☐

Have you ever intentionally physically harmed someone? Yes ☐ No ☐

If yes, when?: _____

Mental Health History:

Are you currently in counseling or therapy elsewhere?: Yes ☐ No ☐

Start of Service	Provider Name and Number	Reason/Diagnosis

Have you ever been involved in counseling, groups, or testing before? Yes ☐ No ☐

Date	Location	Reason/Diagnosis

Have you ever been psychiatrically hospitalized? Yes ☐ No ☐

Date	Location	Reason

Are you currently taking prescribed psychiatric medications? Yes ☐ No ☐

Start Date/Year	Name of Medication	Reason/Diagnosis

Have you taken psychiatric medicine in the past? Yes ☐ No ☐

Year	Name of Medication	Reason/Diagnosis

Treatment History and Goals:

What did you find most helpful about receiving support and treatment? _____

What did you like best about therapy? _____

_____

_____

_____

What is something you would change or improve about the services you received in the past? _____

_____

_____

_____

What is something you would have done differently, when participating in therapy in the past and hope to do/incorporate/include this time in your treatment with this provider? _____

_____

_____

Highlight your personal strengths:_____

_____

_____

Describe your goals for treatment (What would you like to work on? What change or improved in your life would you like to see during treatment)?_____

_____

_____

_____

_____

INSURANCE: [Do not complete if you have provided a copy of your insurance card.]

Health Insurance Carrier: _____ Insurance Policy No: _____

Insurance Phone: _____ Group No: _____

Insurance Address: _____ Cardholder Name: _____

*Please provide if different from client. _____ Cardholder DOB: _____

Card Holder's Address:_____

_____