EVOLVING REFLECTIONS

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue a separate list if needed. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement/Herb	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or fax: _____

How would you rate your current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

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EVOLVING REFLECTIONS

Please list any specific health problems you are currently experiencing:

_____

_____

_____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

_____

_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

_____

_____

How would you rate your current sleeping habits?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- ☐ Falling Asleep
- ☐ Staying Asleep
- ☐ Awakening Early
- ☐ Sleep Apnea

Please list any other specific sleep problems you are currently experiencing:

_____

_____

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Condition	Please Select	Client	Family Member
Alcohol/Substance Abuse	Select		
Anxiety	Select		
Depression	Select		
Domestic Violence	Select		
Sexual Abuse	Select		
Eating Disorders	Select		
Obesity	Select		
Obsessive Compulsive Disorder	Select		
Schizophrenia	Select		
Suicide Attempts	Select		
Other diagnosed mental health condition	Select		

Marital Status:

- ☐ Never Married
- ☐ Domestic Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced For how long? _____
- ☐ Widowed: Please provide your partners name and year deceased:

Name of Partner: _____ Year: _____

If married, how long have you been married for and what is your partners name:

Name of Partner: _____ How Long: _____

On a scale of 1-10 (best), how would you rate your relationship? _____

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Are you currently in a romantic relationship?

☐ Yes -- How long? _____

☐ No

On a scale of 1-10 (best), how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Relationship	Name of other Parent	If deceased, age and cause of death

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

_____

_____

_____

What do you find particularly stressful about your previous work?

_____

_____

_____

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What do you enjoy doing in your free time?

_____

_____

_____

What do you do to relax?

_____

_____

_____

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

_____

_____

_____

What do you consider to be some of your strengths?

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

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