CLEAR ALL

ATHENS NEIGHBORHOOD HEALTH CENTER ANHC

"Keeping Quality Healthcare in the Neighborhood."

Patient Information	**Date:**
Full Name:	Preferred Name:
Parent/guardian (if under 18):	
DOB:	Preferred Pronoun: ◯ He/Him ◯ She/Her
Gender: ◯ M ◯ F	Ethnicity/Race: ◯ W ◯ B ◯ H ◯ MR ◯ NAI ◯ A
Preferred Language:	
Phone Number:	May we leave a message? ◯ Yes ◯ No
Housing status (select one): ◯ Own ◯ Rent ◯ Live with family ◯ Homeless ◯ Staying in a Shelter ◯ Someone's Couch ◯ Facility or Supervised Housing ◯ Section 8 Housing ◯ Supported Apartments ◯ Rehab	
Address:	
City/County/Zip:	
How long have you lived at the address above?	
Number of people living at this address?	
Is housing stable? ◯ Yes ◯ No	
Relationship Status: ◯ Single ◯ Married ◯ Partnership ◯ Separated ◯ Divorced ◯ Serious Relationship ◯ Widowed	
On a scale of 1-10, how would you rate your relationship status? 1	
Do you have any dependents? ◯ Yes ◯ No	
If yes, age and relationship to you:	
Education Information	
Highest level of education:	Type of Degree:
Employment/Income Information	
Employment Status (circle one): ◯ Unemployed ◯ Employed ◯ Disabled ◯ Retired ◯ Student	
Employment type: ◯ Full-time ◯ Part-time ◯ Volunteer ◯ Temporary ◯ Looking for Employment ◯ Student	

Do you receive any of the following (circle all that apply): Food Stamps Unemployment TANF WIC Social Security Disability VA Benefits

Is assistance needed to apply for any of the above services? Yes No

If Yes, which program?

If receiving disability (VA or SS), does it meet your monthly obligations? Yes No

Disability type:

Year of Disability:

Military Information

Have you ever served in the Armed Forces? Yes No

Branch: Highest rank: Ending rank:

Enlistment date: Discharge date:

Discharge type:

MOS/Job Assignment:

# of deployments: Combat exposure: Yes No

Do you receive service benefits through the VA? Yes No

Eligible for VA benefits? Yes No Unsure If yes, percent disabled:

Have you experienced any of the following? PTSD Sexual Trauma IED Exposure Traumatic Brain Injury

Medical/Mental Health Information

Any current medical conditions? Yes No

If yes, please list:

History of (circle all that apply) Epilepsy/Seizure Diabetes Asthma Heart Attack Stroke Cancer TBI

Are you currently pregnant? Yes No

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good

During the past 4 weeks, how many days have you:

	Several Days	Over Half the days	Neary Everyday	No Days
Felt calm and peaceful?				
Had a lot of energy?				
Felt downhearted and blue?				

What significant life changes or stressful events have you experienced recently:

Currently in treatment for mental health: Yes No

If Yes: Name of facility/therapist):

Any previous treatment for mental health: ◯ Yes ◯ No

If Yes: Name of facility/therapist –

Year last in treatment?

Reason for discharge?

Ever been hospitalized? ◯ Yes ◯ No

If Yes: When (year), Where (name of facility), and Why (reason for hospitalization).

Previous mental health diagnoses:

Previously prescribed medication for mental health (List):

Current prescribed medications (List):

Prescribing doctor/clinic:

Medication compliant? ◯ Yes ◯ No

If No: What issues/barriers are responsible for not taking the medications as prescribed?

Approximately how old where you when these symptoms started?

Family history of mental health or behavioral health? ◯ Yes ◯ No

If yes, please list:

Trauma

History of trauma or abuse? ◯ Yes ◯ No Past treatment for trauma or abuse? ◯ Yes ◯ No

Substance Use History

Which substance(s) have you used in the past 6 months:

◯ Alcohol ◯ Marijuana ◯ Stimulant ◯ Hallucinogens ◯ Opioids ◯ Inhalant ◯ Synthetic ◯ Sedative ◯ Hypnotic ◯ Anxiolytic

Route of administration: (all that apply) ☐ Oral ☐ Nasal ☐ Smoke ☐ Intravenous (IV)

How often were you using? Daily : # times per day _____ $ spent per day _____

Length of time for Weekly: # times per week _____ $ spent per week _____

Consistent use: Monthly: # times per month _____ $ spent per month _____

Have you ever experienced or currently experiencing any withdrawal symptoms: ◯ Yes ◯ No

If Yes: What symptoms have you experienced or currently experiencing:

Have you ever experienced any of the following (circle all that apply):

Tremors Delirium Blackouts Intravenous (IV) Use Narcan

Last Narcan Use: # of Overdoses: Last Overdose: # of Narcan uses:

Have alcohol or drugs created problems for you? (job loss, arrest, abuse, financial) Yes No

If Yes, please list:

Previously enrolled in substance use treatment? Yes No

Inpatient Outpatient Residential Accountability Court Program

If Yes: When (year), Where (facility/program),

Did you complete the program? Yes No

What was your age of first use?

Does anyone in your family abuse drugs or alcohol? Yes No

If yes, which family member & what substance:

Referred by (if any):

Reason for Referral/treatment:

Approximately how long has this been causing you problems?

On a Scale of 1 – 10 (1 being the lowest – 10 the highest) How much is the problem interfering with your daily life?

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What do you consider to be your strengths?

What do you consider to be your weaknesses?

What would you like to accomplish out of your time in therapy?

How will you know when therapy has been successful?

X Patient/Guardian Signature Date: