The Healing Journey Therapy Center
115 Hazel Path, Suite 2
Hendersonville, TN 37075

Health History and Social Issues

1. How is your physical health at present?

   ___poor ___fair ___satisfactory ___good ___excellent

2. Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, diabetes, etc.)

   _____

   _____

3. Please list any prescribed medications you are presently taking-

   _____

   _____

4. Are you having any problems with your sleep habits? ___yes ___no
   If yes, check where applicable:

   ___sleeping too little ___sleeping too much

   ___poor quality sleep ___disturbing dreams

   Other: _____

5. How many times per week do you exercise? _____
   For how long? _____

6. Are you having any difficulty with appetite or eating habits? ____yes ____no

   If yes, check where applicable:

   ___eating less ___eating more

   ___binge eating ___restricting calories

   ___significant weight change (in past two months)

7. Do you regularly use alcohol? ___yes ___no
   In a typical month, how often do you have 4 or more drinks in a 24 hr. period?
   _____

8. Have you ever tried to cut down on the amount of alcohol you consume? ____yes _____no

9. Has anyone close to you ever been annoyed by your drinking? ____yes _____no

10. Do you consider your alcohol consumption to be a problem? ____yes ____no ____unsure

11. How often do you engage in recreational drug use?

    ____daily ____weekly ____monthly ____rarely ____never

12. Do you consider this drug use to be a problem? ___yes ____no ____unsure

Mental Health History

1. Are you currently receiving psychiatric services, professional counseling or therapy elsewhere? ____yes ____no

2. Have you ever had previous counseling or psychotherapy? ___yes ____no
   If yes, please specify the following:

   Reason for counseling: _____
   Counseling location: _____
   Counseling date: _____
   Counseling duration: _____

3. Have you ever been hospitalized for psychiatric reasons? ____yes ____no

   If yes, please specify the following:

   Reason for hospitalization: _____
   Hospital location: _____
   Dates of hospitalization: _____
   Duration of hospitalization: _____

4. Have you ever been prescribed medication for psychiatric reasons? ____yes _____no
   If yes, please specify the following:

   Name/dose of medication: _____
   Date of prescription: _____
   Duration of medication: _____
   Physician who prescribed medication: _____