BEHAVIORAL HEALTH INFORMATION

Options
Counseling and Family Services

Client Name: Enter Clients Name Clients Date

Options Location: Options Counseling and Family Services Location: ▼

What services are you seeking? ☐ Therapy ☐ Med Management ☐ Skills Training

What is the main reason you're seeking services at this time?

Please mark any concerns you or your child have in the following areas. (Select only those that apply to the client).
☐ sad, depressed☐ cry easily☐ mood swings☐ can't sleep☐ sleeping too much☐ tired often☐ muscle tension☐ can't eat☐ eating too much☐ feel anxious, nervous☐ panic/anxiety attacks☐ often fearful, afraid☐ easily startled☐ feel overwhelmed☐ worry often☐ feel stressed☐ feel worthless☐ easily angered☐ aggression☐ irritability☐ obsessive behaviors☐ self harm behaviors☐ thoughts of suicide☐ nightmares☐ flashbacks☐ can't remember things☐ can't concentrate☐ hyperactivity☐ problems learning☐ hearing voices ☐ seeing things that are not there☐ alcohol/drug use

The following symptoms affect or may be affected by your (or your child's) behavioral health needs. Please check if any of the following are currently affecting your life.
☐ moving☐ housing concerns☐ homeless☐ job loss☐ death/grief ☐ concerns about children☐ child with special needs☐ abuse in family☐ domestic violence☐ alcohol/drugs in family☐ concerns about a parent☐ family conflicts☐ divorce☐ relationship concerns☐ pregnancy☐ physical health concerns☐ legal issues/criminal record

Are you (or your child) currently taking any medications?

○Yes
○No

If yes, what?

Other concerns or issues:

Client Name :

Relation to Client : ○Self○Parent / Guardian○Legal Custodian○Guardian○Other, as listed

X _____

Signature Certificate

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