

## BEHAVIORAL HEALTH INFORMATION



Client Name:

Options 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



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# Signature Certificate

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