Blue Mountain Center for Integrative Health
828-265-1455
Email: info@bluemountaincenternc.com
Website: www.bluemountaincenternc.com

Personal Information and History Form

*** This information will be kept confidential. ***

Thank you for printing clearly. Today's Date: _____

Name: _____ Birth Date: _____ Age: _____

Local Mailing Address: _____

_____

Social Security Number: _____-____-_____ Telephones: Home: _____

Work: _____

Email: _____ Cell: _____

Employment Status: ____ work full time ____ work part time ____ not employed outside the home

Employer or Business Name: _____

Employer's Address: _____

_____

Your Job or Position: _____

Student Status: _____ full time _____ part time _____ not currently in school

School Name: _____ Location: _____

If you are under 18:

Parent's or Guardian's Name: _____ Phone: _____

Parent's or Guardian's Address: _____

_____

Who is responsible for payment?

Name: _____

Mailing Address (if not given above): _____

_____

Insurance/Managed Care Company (only if you are using this to pay for our services):

_____

Address: _____ Phone: _____

_____

Your Individual Policy Number: _____ Group I.D.#: _____

Name of Insured Policyholder: _____

Relationship to you: _____ Their Date of Birth: _____

Their place of employment, if relevant to insurance policy: _____

_____ My policy DOES cover mental health services.

My copay amount per session: $____. Current amount left of my deductible $_____

PLEASE NOTE: You are responsible for any charges that your insurance does not cover.

In case of emergency, a relative or friend we should contact:

Name: _____ Phone: (h)_____

Address: _____ (w) _____

_____ (c) _____

Relationship to you: _____

(Continued. . .)

Your personal/family physician: _____ Phone: _____
Address: _____

Other current health care providers (including medical specialist, chiropractic physician, naturopathic physician, physical therapist, massage therapist/body worker, nutritionist, herbalist, healing touch/Reiki/energy worker, etc.):

_____
_____
_____

Please list any current physical health problems you are experiencing:

_____
_____
_____

Please list any medications that you are currently taking. Please include pharmaceuticals, herbal and homeopathic remedies, nutritional supplements, etc.) and the condition or reason for using each one:

_____
_____
_____
_____

Please list any other medications you use frequently or may have used recently, which are not listed above as "current."

_____
_____
_____
_____

How did you learn about our services? Who referred you to us?

_____

If this is an individual, may we thank her or him for referring you? _____
Contact Information: _____

Reasons for seeking our services at this time:

_____
_____
_____
_____
_____

I confirm that the information given on this form is accurate to the best of my knowledge at this time. I understand that the information requested on the following pages is optional, and I may leave blank any questions I prefer not to answer at this time.

_____ _____
(Signature) (Date)

(Continued. . .)

Family and Relationship Information

Current Relationship Status (Please check all that apply):

_____ single, not dating anyone _____ single and dating
_____ in a committed partnership _____ married, living together
_____ separated from committed relationship or marriage (when? _____)
_____ divorced (when? _____) _____ widowed (when?_____)

Current Partner's Name: _____ Age: _____
How long have you been in this relationship? _____
If you are married, how long have you been married? _____

If you are separated: _____from marriage _____ from other committed partnership
Approx. date of separation: _____ Length of relationship prior to separation: _____
Separation initiated by: ____ you _____ your partner/spouse ___ mutual agreement
Are you actively working <u>together</u> toward reconciliation? ____ yes ____ no ____ unsure
Is <u>one</u> of you seeking reconciliation? _____ you _____ partner/spouse _____ unsure
Comments: _____

If you are divorced: Date of divorce: _____ Length of marriage: _____
Divorce initiated by: ___ you ___ your ex-spouse ___ mutual consent
Quality of current relationship with ex-spouse:
___ supportive, friendly relationship ___ cooperative relationship
___ conflictual relationship ___ no communication at all
Comments: _____

Current Living Situation (Please check all that apply):

___ live alone ___ live with non-related housemate(s)
___ live with partner/spouse ___ live with child(ren)
___ live with other family member(s) ___ other (specify) _____
Comments: _____

Please list those who currently live in your home, even part-time:

Name	Age	Relationship to you	Comments

Please list any children you have who are <u>not</u> currently living with you.

Name	Age	Location (City/State)	Living Situation (e.g., lives at school, lives with own partner, etc.)

Any pets that currently share your home with you: _____
_____

(Continued. . .)

Have you or your partner/spouse ever had a miscarriage? _____ Approx. date(s): _____
A stillbirth? _____ Other death of a child? _____ Approx. date(s): _____
Comments: _____
Have you or your partner/spouse ever had an abortion? _____ Approx. date(s): _____
Comments: _____

Death or loss of any other people or animals important to you (approx. dates and relationship to you):

_____

_____

Please list your **brothers and/or sisters**, along with any **half- or step-siblings**:

Name	Number of Years Older of Younger than You	# of Years Living in Same House with You	Current Relationship with You Any Other Comments

Please list any **other family members** (parents, cousins, grandparents, etc.) who are not currently living with you but with whom you still have some contact/communication/relationship:

Name	Relationship to You	Location (City, State)	How supportive is she or he of you?

How many **current friends** do you have with whom you can honestly share your feelings and speak about important personal issues, who are likely to be supportive of you? _____
Comments: _____

Please list any **groups**, **church or other spiritual/religious organizations**, **civic groups**, **clubs**, **volunteer activities**, **service projects**, etc. **in which you personally participate**, at least with your attendance (not just sending dues in the mail or reading a newsletter):

Group	Type of Participation	How Long a Participant/Member?	How much is it a possible source of personal support for you?

Mental Health History

Please list previous counseling/therapy (individual, couple, family, or group) or psychiatric hospitalization experiences from most recent to longest ago. Use additional paper if needed.

Approx. Dates (From – To)	Reason for Therapy or Hospitalization	Therapist or Hospital Name	Location	If Ended, Reason for Stopping

(Continued. . .)

Please list any **family member's therapy/psychiatric hospitalization** experiences:

Name	Relationship to You	Approx. Dates	Reason for Therapy or Hospitalization

Alcohol & Other Drug Use History (Recreational/Social – Not Prescription Used Appropriately)

How often do you have **a drink containing alcohol** *(pick the answer that fits best for you)*
___ Never ___ 0-1 time/month ___ 2-4 times/month ___ 2-3 times/week ___ 4 or more times/week
Standard Drink: How many standard drinks containing alcohol do you have on a typical day?
___1 or 2 ___3 or 4 ___5 or 6 ___7 to 9 ___10 or more
How often do you have **6 or more drinks on one occasion**?
___ Never ___ Less than monthly ___ Monthly ___ Weekly ___ Daily or almost daily
Caffeine products: what types do you consume? _____
amount per day (average)? _____
Tobacco/ nicotine products: what type(s) _____
amount per day (average) _____

Please list your use of **other psychoactive (mood altering) drugs:** Start with current use, and historically include only those drugs used more than 5 or 6 times, unless fewer times were significant.

Name/Type of Drug	Reason(s) for Using	Approx. Dates (From – To)	How Much? How Often? (Per day/week)	Still Using or Reason Stopped

Please list any **family members** whom you suspect have had **alcohol/other drug problems or addictions:**

Name	Relationship to You	Brief Description of Problem	Still Using?

Gambling

Have you ever tried to stop, cut down or control your gambling? _____
Have you ever lied to family members, friends, or others about how much you gamble or how much money you lost gambling? _____
Have you ever felt the need to bet more and more money? _____
Do you think you have ever been affected by someone else's gambling? _____

Please list and briefly describe **any behavior patterns** that concern you involving eating, spending, relationships, sex, phobias, anger, video/computer gaming, gambling, shoplifting, self-injury, etc.:

_____
_____
_____ (Continued. . .)

History of Abuse/Assault

Please fill in the spaces that apply to you:

IN YOUR CHILDHOOD **Type of Abuse Done TO YOU**	Ever experienced **when you were a child or teen** by adults or other kids	By Whom?	Your Approx age(s)	Their approx. age(s)	Ever told before? If yes, whom?
VERBAL/EMOTIONAL ABUSE: humiliated, intimidated, threatened, insulted, controlled, etc.					
PHYSICAL ABUSE: hit, slapped, kicked, choked, burned, restrained, etc. (potential pain/injury)					
SEXUAL ABUSE: coerced or pressured or forced into sexual situations or unwanted sexual contact					

What **YOU** Have Done Type of Abuse	Have **YOU** ever done this **to a child?**		Your approx. age(s)	Their approx. age(s)	Ever told before? If yes, whom?
	As a child/teen	As an adult (you)?			
EMOTIONAL/VERBAL ABUSE					
PHYSICAL ABUSE					
SEXUAL ABUSE					

Please list other family members whom you know or suspect were victims or offenders of abuse and describe briefly: _____

_____

ADULT Domestic Violence and Sexual Assault

(In Your Late Teen and Adult Life)

Has a partner/spouse/date ever physically abused you (see definition above)? _____
Approx. date(s), comments: _____

Have you ever physically abused your partner/spouse/date? _____
Approx. date(s), comments: _____

Have you ever experienced unwanted, forced/coerced sexual contact as an adult or older adolescent (other than as listed above)? _____
Approx. date(s), comments: _____

As an adult or adolescent, have you coerced or forced an unwilling adolescent or adult into sexual contact with you? _____ Approx. date(s), comments: _____

Please share any remaining concerns or important information that may assist us in helping you.

_____

_____

_____

_____

Thank you.

Name: _____

Today's Date: _____

Blue Mountain Center for Integrative Health

Integrative Health/Wellness Survey

Please circle the number for each item that best fits you right now.

Feel free to write any comments you wish below or beside each item.

Overall Health and Wellness

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Physical Health

fitness, strength, flexibility, stamina, nutrition, sleep, physical activity, feeling well

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Psychological/Emotional Health

emotional stability, ability to focus, self acceptance, optimism, confidence, managing life, appropriate emotional expression

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Healthy Personal Relationships

satisfying connection to friends and/or family, feeling understood & supported, significant relationships, good communication and problem-solving skills, balance of give-and-take

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Healthy Community/Cultural Connections

feeling a part of my community (communities), involvement in community activities, support for my cultural/multicultural identity, comfort being myself in my community

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Intellectual/Mental/Cognitive Health

intellectual stimulation, creativity, memory, organization, enjoyment of learning, ability to calm or focus thoughts

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Occupational Health

satisfactory or fulfilling work, safe/non-toxic work environment, respectful treatment at work, realistic expectations of work, reasonable/appropriate compensation, comfort being myself at work

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

(Continued)

Environmental Health
enjoyment of the natural world, time outdoors, eco-friendly practices, clutter reduction
pleasant surroundings

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Financial Health
financial security, low debt level, living within financial means, ability to save money,
shared financial decisions within household, financial planning for the future

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Spiritual Health
finding meaning in life, making time for spiritual connection/practice, peace with myself.
acceptance of my life

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Sexual Health
comfort with emotional intimacy, healthy sexual boundaries, creation of a safe sexual environment,
able to communicate well about sex and sexuality

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Recreational/Leisure Health
engaging in pleasurable activities, having fun, laughter, healthy ways to relax alone and with others

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Creative Health
participation in creative activities, flexible thinking in work and other settings,
valuing of my own and others' creativity

poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Other:
Are there any other important aspects of your overall health or wellness you want to identify?

Thank you!