Meraki Healthcare
COMPASSIONATE COUNSELING SERVICES
3393 E Merlin Drive Suite A, Idaho Falls, ID 83404
Ph: 208 643-5343
Fax: 405-259-0767

MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____

Patient's Primary Care Physician: _____

Physician Phone number: (_____)_____

Pharmacy and Address : _____

Pharmacy Phone Number: (_____)_____

Medical History (Diabetes, asthma, cancer, heart disease, ect.)

_____

_____

_____

Surgical History: YES or NO (Please Circle One).

IF yes, Please explain Surgical History:_____

_____

ALLERGIES: YES or NO (Please circle one).

If yes, Please Explain below: _____

OVER THE COUNTER MEDICATIONS: (Ibuprofen,Aspirin, Tylenol, Vitamins, etc).

_____

_____

FAMILY HISTORY: (Medical illnesses, Surgeries)

_____

_____

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SOCIAL HISTORY

Smoke? YES or NO (Please circle one).

If yes, how many packs per day?: _____

How many years?: _____

Alcohol? YES or NO (Please circle one).

If yes, How much per day? _____

Is there a history of mental illness in your family?

If yes, Please explain: _____

What is your level of education? (Highest grade/ degree and type of degree).

_____

What is your current Occupation? What do you do ? How long have you been doing it?

_____

_____

Describe your current living situation. Do you live alone, with others, with family, etc.

_____

_____

If you have had Psychological Testing, please list the providers name and phone number so we can obtain records:

_____

_____

List all current medications (include name, dose, and prescriber):

_____

_____

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If you have experienced anything in the past 6 months please check any of the following that may apply to you or you have experienced.

- Increased appetite
- Decreased appetite
- Trouble concentrating
- Difficulty sleeping
- Excessive Sleep
- Low motivation
- Isolation from others
- Fatigue/ low energy
- Low self-esteem
- Depressed mood
- Tearful or crying spells
- Anxiety
- Fear
- Hopelessness
- Panic
- Other

_____
_____
_____

Please Check any of the following that apply to you:

- Headaches
- High blood pressure
- Gastritis or Esophagitis
- Hormone-related problems
- Head injury
- Angina or chest pain
- Irritable bowel
- Chronic Pain
- Loss of Consciousness
- Heart Attack
- Bone or Joint problems
- Seizures
- Kidney-related issues
- Chronic Fatigue
- Dizziness
- Faintness
- Heart valve problem
- Urinary tract problems
- Fibromyalgia
- Numbness & tingling
- Shortness of Breath
- Diabetes
- Hepatitis
- Asthma
- Arthritis
- Thyroid issues
- HIV/AIDS
- Cancer
- Other

_____
_____
_____

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What brings you to our clinic at this time? Is there something specific, such as a particular event? Be detailed as you can.

_____
_____
_____.

What are your goals for counseling or medication management?

_____
_____
_____.

Have you seen a mental health professional before?

_____
_____
_____.

Have you ever attempted suicide? Yes or No (Please circle one).

If yes, Please explain

_____
_____
_____.

Do you have thoughts or urges to harm yourself or others? Yes or no (Please circle one)

If yes, Please explain

_____
_____
_____.

Have you ever been hospitalized for a psychiatric issue? Yes or no (Please circle one)

If yes, Please explain

_____
_____
_____.

If you are in a relationship, please describe the nature of the relationship and months or years together.

_____
_____
_____.

What else would you like me to know about you?

_____
_____

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Depression Screener:

Client Name: _____DOB:_____Date:_____

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things?

   0 1 2 3

2. Feeling down, depressed, or hopeless?

   0 1 2 3

3. Trouble falling or staying asleep, or sleeping too much?

   0 1 2 3

4. Feeling tired or having little energy?

   0 1 2 3

5. Poor appetite or overeating?

   0 1 2 3

6. Feeling bad about yourself, or that you are a failure or have let yourself or your family and others down?

   0 1 2 3

7. Trouble concentrating on things, such as reading the newspaper, or watching television?

   0 1 2 3

8. Moving or speaking so slowly that other people could have seen or noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more often?

   0 1 2 3

9. Thoughts that you would be better off dead or hurting yourself in some way?

   0 1 2 3

Office Score: _____