HEALTH QUESTIONNAIRE

NAME: _____ **TODAY'S DATE:** _____

Birthdate: _____ **Primary Care Physician Name & Phone:** _____

_____

HEALTH HISTORY:
Do you have any FOOD or DRUG ALLERGIES: No Yes If yes, please list _____

_____

Do you have any physical impairments or limitations which may require special accommodations, special arrangements, or may affect your treatment (i.e. reading difficulties, hearing loss, vision loss, speech impairment)? No Yes
If yes, please explain _____

_____

How would you describe the nutritional value and balance of your diet: Good Fair Poor

Do you exercise regularly: No Yes If yes, please list type and frequency of exercise: _____

_____

Symptoms in the past 6 months: (Please check all that apply)

Headaches	Compulsions	Stomach / Bowel Distress
Depressed	Anxious	Excessive Fears
Crying	Worry	Periods of Overactivity
Guilt	Nervous	Mood Swings
Sleep Disturbance	Change in Appetite	Eating Problems
Low Self-esteem	Social Withdrawal	Irritable / Temper
Sad	Change in Energy	Hostile / Angry
Hopelessness	Helplessness	Poor Concentration
Obsessions	Lack of Pleasure	Apathy
Weight Change	Low Motivation	Poor Memory
Sexual Difficulty	Suicidal Thoughts	

Are you **currently** on any physician prescribed medications or regularly take any "over-the-counter" or herbal medications, including any prescriptions for anxiety, depression, or other mental health conditions? No Yes
If yes, please list all medications:

Medication / Purpose	Dosage / Times per Day	How long?	Do you take this medication consistently?
			Yes No

			Yes	No
			Yes	No
			Yes	No
			Yes	No

In the **past,** have you ever taken medication for a mental health condition? No Yes If yes, please describe:

Hospitalizations / surgeries? No Yes If yes, please describe (include dates, complications, & outcomes): _____

Do you have any medical conditions? No Yes If yes, please describe:_____

How many pregnancies have you had: _____ Any complications? No Yes If yes, please describe: _____

Have you ever had a miscarriage? No Yes If yes, when and at what point in the pregnancy did it occur: _____

Have you ever had an abortion? No Yes

BEHAVIORAL HEALTH

Have you had prior psychiatric counseling or alcohol/drug treatment? No Yes
If yes, please list names and dates below:

OUTPATIENT

Therapist/Doctor or Program Name: **Date:**

INPATIENT

Hospital: **Date:**

Regarding past treatment, what did you find most helpful to you?

What was least helpful?

HOBBIES / INTERESTS: _____

SUBSTANCE USE HISTORY:
Have you experienced any of the following problems as a result of alcohol, prescription medications, or other drug use?
No Yes If yes, please check any that apply:

_____ financial problems _____ relationship problems _____ work problems
_____ increased tolerance _____ physical problems _____ emotional problems
_____ blackouts _____ withdrawal symptoms _____ cravings
_____ Legal Involvement _____ DUI
Comments/details on above: _____

Has anyone in your family had problems with alcohol or other drug use? No Yes If yes, please explain:

_____

_____

Please indicate the following:

SUBSTANCE	AMOUNT	FREQUENCY	DURATION	FIRST USE	LAST USE
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opiods / Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Other					

HISTORY OF ABUSE:
Have you ever experienced: Physical Abuse Rape/Sexual Assualt Date Rape Sexual Abuse
Verbal/Emotional Abuse Early Exposure to Pornography Domestic Violence Other Trauma
Please comment:

_____

_____

CULTURAL/ETHNIC/SEXUAL:
Do you have any cultural, ethnic or racial issues that need consideration? _____

_____

Do you have any sexual orientation issues that need consideration? _____

_____

MILITARY SERVICE: No Yes Type of Discharge: _____
Were you involved in combat duty? No Yes If yes, please describe: _____

_____

EMPLOYMENT: Currently employed? No Yes Job Title: _____ Duration _____

EDUCATION: Highest grade completed _____ Diploma: No Yes

SPIRITUAL HISTORY:
Is spirituality an important resource for you? No Yes If yes, does your practice of spirituality include:
Attendance at religious services? No Yes Frequency: _____
Practice of spiritual disciplines such as prayer, reading, or meditation? No Yes
Involvement in some type of ministry No Yes
Involvement in a small group or with a spiritual director or mentor? No Yes

FAMILY HISTORY:
Is there any history of emotional / mental health problems, or suicide in the family? No Yes
If yes, please explain:
_____
_____

Number of siblings: _____ Please describe your relationship with siblings: _____
_____
_____
_____
_____
Please describe your relationship with your parents:
_____
_____
_____

MARITAL HISTORY:
Single Married Divorced Widowed Partner

Spouse's Name and Age: _____
Duration of Marriage: _____
Any Separations? _____
Children's Names & Ages: _____
_____
Number of previous marriages and reasons for divorce: _____
_____
_____
Please describe current status of marriage: _____
_____
_____

LEGAL HISTORY:
Have you ever had involvement with the legal system? No Yes If yes, please explain when, what involvement, and the outcome: _____
_____
_____
Do you have any current pending legal charges? No Yes If yes, please explain: _____
_____
_____

Are you currently on probation or parole? No Yes Have you ever been incarcerated? No Yes

The information I have provided above is true to the best of my knowledge.

_____ _____
Client Signature *Date*