CREATING HEALTHY ALTERNATIVES TOGETHER FORENSIC AND CLINICAL ASSESSMENT SERVICES

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	
	Today's date:	

PERSONAL HEALTH HISTORY

Primary reason for seeking service:

☐ Anger management	☐ Anxiety	☐ Coping
☐ Eating disorder	☐ Fears/Phobias	☐ Mental confusion
☐ Sleeping problems	☐ Addictive behaviors	☐ Alcohol/drugs
☐ Depression	☐ Sexual concerns	☐ Other mental health concern:

If "Other", please describe:

List any medical problems that other doctors have diagnosed:

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Drug Name	Strength	Frequency Taken
Allergies to medications:		
Drug Name	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes –pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐Or year quit				

Drugs	Do you currently use recreational or controlled substances?	☐ Yes	☐ No
	If yes, what kind?		
	How many times per week?		
	Have you ever given yourself controlled substances with a needle?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐M ☐F	
Mother				☐ M ☐ F	
Sibling	☐M ☐F			☐ M ☐ F	
	☐M ☐F			☐ M ☐ F	
	☐M ☐F		**Grandmother** *Maternal*		
	☐M ☐F		**Grandfather** *Maternal*		
	☐M ☐F		**Grandmother** *Paternal*		
	☐M ☐F		**Grandfather** *Paternal*		

PHYSICAL HEALTH

☐ AIDS	☐ Dizziness	☐ Nose bleeds
☐ Alcoholism	☐ Drug abuse	☐ Pneumonia
☐ Abdominal pain	☐ Epilepsy	☐ Rheumatic fever
☐ Abortion	☐ Ear infection	☐ Sexually transmitted diseases
☐ Allergies	☐ Eating problems	☐ Sleeping disorder
☐ Anemia	☐ Fainting	☐ Sore throat
☐ Appendicitis	☐ Fatigue	☐ Scarlet fever
☐ Arthritis	☐ Headaches	☐ Sinusitis
☐ Asthma	☐ Hearing problems	☐ Smallpox
☐ Bronchitis	☐ Hepatitis	☐ Stroke
☐ Cancer	☐ High blood pressure	☐ Sexual problems
☐ Chest pain	☐ Kidney problems	☐ Tonsillitis
☐ Chronic pain	☐ Measles	☐ Tuberculosis
☐ Colds/Coughs	☐ Mumps	☐ Thyroid problems
☐ Constipation	☐ Miscarriage	☐ Vision problems
☐ Chicken pox	☐ Menstrual pain	☐ Vomiting
☐ Diabetes	☐ Neurological disorder	☐ Whooping cough
☐ Diarrhea	☐ Nausea	☐ Other: _____

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No
Have you ever been treated for drugs or alcohol?	☐ Yes	☐ No
Are you involved with self-help groups?	☐ Yes	☐ No

SYMPTOMS

☐ Aggression	☐ Elevated mood	☐ Phobias/fears
☐ Alcohol dependence	☐ Fatigue	☐ Recurring thoughts
☐ Anger	☐ Gambling	☐ Sexual addiction
☐ Antisocial behavior	☐ Hallucinations	☐ Sexual difficulties
☐ Anxiety	☐ Heart palpitations	☐ Sick often
☐ Avoiding people	☐ High blood pressure	☐ Sleeping problems
☐ Chest pain	☐ Hopelessness	☐ Speech problems
☐ Cyber addiction	☐ Impulsivity	☐ Suicidal thoughts
☐ Depression	☐ Irritability	☐ Thoughts disorganized
☐ Disorientation	☐ Judgment errors	☐ Trembling
☐ Distractibility	☐ Loneliness	☐ Withdrawing
☐ Dizziness	☐ Memory impairment	☐ Worrying
☐ Drug dependence	☐ Mood shifts	☐ Other (specify):
☐ Eating disorder	☐ Panic attacks	

OTHER CONCERNS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	