

**Date:**

HEALTH HISTORY QUESTIONNAIRE

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



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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** (Last, First, M.I.): |  |  |  |  | M | F |  | **DOB:** |
| **Marital status:** | Single | Partnered | Married | Separated | Divorced | Widowed |

MENTAL HEALTH HISTORY

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have you ever seen a mental health provider for any reason (this includes, psychiatrist, psychologist, counselor, etc)?** |  | Yes |  | No |
| **If yes, when and why?** |
| **Year** | **Reason** | **Hospitalized?** |
|  |  |  | Yes Yes Yes YesYes |  | No No No NoNo |
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| **Have you ever made a suicide attempt or thought about it?** |  | Yes |  | No |
| **If so, when?** |

SYMPTOM SCREEN

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you ever been sad or depressed for more than two weeks? |  | Yes |  | No |
| Have you ever had so much energy that you didn’t need to sleep, and made big plans or bad decisions? |  | Yes |  | No |
| Have you ever been so anxious that you couldn’t do anything, or even leave the house? |  | Yes |  | No |
| Do you often feel that you need to count, check or clean things in a special way? |  | Yes |  | No |
| Do you ever have several minutes of extreme anxiety and fear that comes out of the blue? | Yes |  | No |
| Do you ever feel that you can’t control your thoughts or that people can read or control your mind? |  | Yes |  | No |
| Have you ever thought about someone so much that you followed them? |  | Yes |  | No |
| Do you have trouble sleeping? |  | Yes |  | No |

MEDICAL HISTORY

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have any medical illnesses? |  | Yes |  | No |
| If yes, please list | Problem | Year diagnosed |
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| **Hospitalizations** |
| Year | Reason | Hospital |
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| --- |
| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** |
| Name the Drug | Strength | Frequency Taken |
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| **Allergies to medications** |
| Name the Drug | Reaction You Had |
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|  |  |

HEALTH HABITS

* None

Cola

Tea

Coffee

**Caffeine**

Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)

Mild exercise (i.e., climb stairs, walk 3 blocks, golf)

Sedentary (No exercise)

**Exercise**

|  |  |
| --- | --- |
|  | # 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 ever experienced blackouts? |  | Yes |  | No |
| Are you prone to “binge” drinking? |  | Yes |  | No |
| Have you received treatment for drug or alcohol addiction? |  | 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 street drugs? |  | Yes |  | No |
| Have you ever given yourself street drugs with a needle? |  | Yes |  | No |

FAMILY MENTAL HEALTH HISTORY



|  |
| --- |
| AGE MENTAL HEALTH PROBLEMS AGE MENTAL 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 |  |  |
| **Any other family members with mental/emotional problems? If so, who?** |  |  |  |  |
| Yes | No |

DEVELOPMENTAL AND OCCUPATIONAL HISTORY

|  |
| --- |
| Where were you born and raised? |
| To your knowledge, did you develop normally as a child? (physically and mentally): |  | Yes |  | No |
| Did you have any problems in school? (discipline or behavioral ) |  | Yes |  | No |
| Any legal problems as a child? |  | Yes |  | No |
| Did you ever? | Hurt animals for fun?Skip school? Set fires for fun? |  | Yes |  | No |
|  | Yes | No |
|  | Yes |  | No |
| Have you ever been physically or sexually abused? |  | Yes |  | No |
| Have you ever served in the military? |  |  |  |
|  |  |  | Yes |  | No |
| What was your rank? | Type of Discharge? |  |  |  |

|  |
| --- |
| What was your last level of education completed? |
| What is your current occupation? |
| How many times have you been married? How many children do you have? |

LEGAL HISTORY AND MISCELLANEOUS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have your ever been arrested? |  | Yes |  | No |
| If yes, list when and for what | Charges | Year |
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| Check if you have been involved in any of the following: |
|  |  | Personal injury litigation |  | Termination/suspension from a professional society or managed care/insurance panel |  |
|  |  |  |
|  |  | Sexual Harassment complaints |  |  |  | Any professional/administrative complaints |
|  |  | Workers Compensation claims |  |  |
|  |  | Bankruptcy |  |  |

**Space for Additional Comments**