Name/Date:

Health History Questionnaire

Please answer the following questions as fully as possible. All information is confidential. If there is an item you would prefer to discuss in person only, please indicate so.

Please list your main reason, as well as any secondary reasons(recent stressors), for your visit:

_____

_____

Average hours of sleep/night:_____

If you experience problems with sleep, please describe. Do you have trouble going to sleep, staying asleep, waking early?_____

Have you experienced changes in appetite? If so, please describe:_____

Type and frequency of exercise _____

Past History:

Prior psychiatric or chemical dependency services:

Treatment setting:_____

Dates of service:_____

Ever hospitalized for psychiatric reason? YES NO Dates:_____

Previous diagnoses? _____

Have you ever attempted suicide? YES NO Dates:_____

Please list ALL medications you have taken to treat psychiatric illnesses, the length of time you took them, and the approximate date you started them. Include medications you are currently taking.

_____ _____

_____ _____

_____ _____

Drug, Alcohol & Tobacco History:

Average number of cigarettes per day: _____ For how long? _____

How much caffeine do you drink each day? _____

Average number of alcoholic drinks per week: _____ For how long? _____

List any street drugs you use or have experimented with (no matter how infrequently):

_____

Current drug use, including marijuana? _____ Daily? YES NO If not daily, how often? _____

Have you ever felt you should cut down on your drinking or drug use? Yes No

Do you get annoyed by people's comments about your drinking or drug use? Yes No

Have you ever felt guilty or bad about your drinking or drug use or its effects? Yes No

Name/Date:

Have you ever had a drink or used drugs in the morning to help you get going? Yes No

Describe any recent or past exposure to trauma (sudden, unanticipated death of a friend or relative, sexual trauma, car accident, death of a child, witness to violence) of any kind:

_____

_____

Family History of Psychiatric or Chemical Dependency Problems:

Do you have any family history of psychiatric or chemical dependency problems? If so please describe below.

_____

_____

_____

_____

Medical History:

List any medical problems now or in the past that have required treatment by a doctor or other provider (e.g., chiropractor, acupuncturist.) Include surgeries and the dates that they occurred.

_____ _____

_____ _____

_____ _____

Are you currently experiencing any physical symptoms or illnesses, if so please describe?

_____

Allergies:

Have you **ever** had an allergic or other bad reaction to medicines? Please list and describe the reaction.

_____ _____

Have you ever had a head injury/lost consciousness from one? Yes No Dates:

Have you ever had a seizure? Yes No Dates:

List all medications you currently take for reasons other than psychiatric, including frequency and dose. Remember to include over-the-counter medicines, herbal remedies, and supplements.

_____ _____

_____ _____

_____ _____

For women only:

Are you pregnant? YES NO Date of the start of your last period: _____

How many pregnancies have you had? _____ How many live births? _____

Name/Date:

Any depression after childbirth?_YES NO Treatment?_____

What method of contraception are you using now? _____

Are you now using or have you used hormone replacement therapy for any reason? Y N

Home & Environment:

Are you currently sexually active with others? Yes No

How do you describe your sexual orientation? _____

Marital status: Single Married Long-term partnership Other

Length of current relationship: _____

How happy are you with the relationship? Very Somewhat Not very Not at all

Please give the sex, age and health problems of any biological/adopted/step children:

_____ _____

_____ _____

Who do you consider to be your primary social supports? _____

Education/Occupation:

Highest level of education completed _____

How many hours/week do you work? _____

If not currently working outside the home, date you last worked _____ What type of work?

_____