HEALTH QUESTIONNAIRE/MEDICAL HISTORY

Name:_____ Date of Birth:_____ Date: _____

This questionnaire is about your health. This information is confidential.

1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be **contagious** to others around you? If yes, please give details.
   No ☐ Yes ☐ Date:
2. Have you ever had a stroke? If yes, please give details.
   No ☐ Yes ☐ Date:
3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes, please give details.
   No ☐ Yes ☐ Date:
4. Have you ever had any form of seizures, delirium tremens or convulsions? If yes, please give details.
   No ☐ Yes ☐ Date:
5. Have you experienced or suffered any chest pains? If yes, please give details.
   No ☐ Yes ☐ Date:
6. Have you ever had a heart attack or any problem associated with the heart? If yes, please give details.
   No ☐ Yes ☐ Date:
7. Do you take any medications for a heart condition? If yes, please give details.
   No ☐ Yes ☐ Date:
8. Have you ever had blood clots in the legs or elsewhere that required medical attention? If yes, please give details.
   No ☐ Yes ☐ Date:
9. Have you ever had high blood pressure or hypertension? If yes, please give details.
   No ☐ Yes ☐ Date:
10. Do you have a history of cancer? If yes, please give details.
    No ☐ Yes ☐
11. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.
    No ☐ Yes ☐
12. Do you have any allergies to medications, foods, animals, chemicals, or any other substance? If yes, please give details.
    No ☐ Yes ☐ Date:
13. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If yes, please give details.
    No ☐ Yes ☐ Date:
14. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.
    No ☐ Yes ☐ Date:
15. Have you ever been diagnosed with any type of hepatitis or other liver illness? If yes, please give details.
    No ☐ Yes ☐ Date:
16. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If yes, please give details.
    No ☐ Yes ☐ Date:
17. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.
    No ☐ Yes ☐ Date:
18. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder? If yes, please give details.
    No ☐ Yes ☐ Date:
19. Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If yes, please give details including any ongoing pain or disabilities.
    No ☐ Yes ☐ Date:

20. Please describe and date any surgeries or hospitalizations due to illness or injury that you have had.

_____

_____

_____

21. When was the last time you saw a physician? What was the purpose of the visit?

_____

22. Do you take any prescription medications including psychiatric medications? If yes, please list type(s) and dosage(s).
No ☐ Yes ☐

23. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If yes, list the medication(s) and how often you take it?
No ☐ Yes ☐

24. Do you take over the counter digestive medications such as Tums or Maalox? If yes, list the medication(s) and how often you take it.
No ☐ Yes ☐

25. Do you wear or need to wear glasses, contact lenses, or hearing aids? If yes, please give details.
No ☐ Yes ☐

26. When was your last dental exam? Date:_____

27. Are you in need of dental care? If yes, please give details.
No ☐ Yes ☐

28. Do you wear or need to wear dentures or other dental appliances that may require dental care? If yes, please give details.
No ☐ Yes ☐

29. Are you pregnant? No ☐ Yes ☐ Due Date:

30. **In the past seven days** what types of **substances**, including alcohol, have you used?

Type of Drug	Route of Administration

31. **In the past year** what types of **substances**, including alcohol, have you used?

Type of Drug	Route of Administration

32. Please list **current medications**, including over-the-counter medications:

Type of Medication	Dosage

33. Do you have a Primary Care Physician? No ☐ Yes ☐
If yes, whom do you see? _____

Date of last visit and reason: _____

I declare that the above information is true and correct to the best of my knowledge:

Client Signature:_____ Today's Date:_____

Therapist Signature:_____ Today's Date:_____