

Date:

HEALTH HISTORY QUESTIONNAIRE

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

Name <small>(Last, First, M.I.):</small>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
Marital status:	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Married
	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> 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?			
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had so much energy that you didn't need to sleep, and made big plans or bad decisions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been so anxious that you couldn't do anything, or even leave the house?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you often feel that you need to count, check or clean things in a special way?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever have several minutes of extreme anxiety and fear that comes out of the blue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever feel that you can't control your thoughts or that people can read or control your mind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever thought about someone so much that you followed them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEDICAL HISTORY

Do you have any medical illnesses? Yes No

If yes, please list	Problem	Year diagnosed

Hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS

Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola

	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you received treatment for drug or alcohol addiction?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY MENTAL HEALTH HISTORY

	AGE	MENTAL HEALTH PROBLEMS		AGE	MENTAL HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		
	Any other family members with mental/emotional problems? If so, who?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

DEVELOPMENTAL AND OCCUPATIONAL HISTORY

Where were you born and raised?		
To your knowledge, did you develop normally as a child? (physically and mentally):		<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you have any problems in school? (discipline or behavioral)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Any legal problems as a child?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you ever?	Hurt animals for fun?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Skip school?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Set fires for fun?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been physically or sexually abused?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever served in the military?		<input type="checkbox"/> Yes <input type="checkbox"/> 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 you ever been arrested?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If yes, list when and for what	Charges	Year			

Check if you have been involved in any of the following:			
<input type="checkbox"/>	Personal injury litigation	<input type="checkbox"/>	Termination/suspension from a professional society or managed care/insurance panel
<input type="checkbox"/>	Sexual Harassment complaints	<input type="checkbox"/>	Any professional/administrative complaints
<input type="checkbox"/>	Workers Compensation claims		
<input type="checkbox"/>	Bankruptcy		

Space for Additional Comments