HEALTH HISTORY QUESTIONNAIRE

This form should be completed as fully as possible by the client or parent/guardian and reviewed by medical or clinical staff.

attach additional pages as needed

DOB	**Client's Name (First, Last)**

Has the client had any of the following health problems? (Check all that apply)

Problem	Past	Current	N/A	Family History?	Problem	Past	Current	N/A	Family History?
High Blood Pressure	☐	☐	☐	☐	Anxiety	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Learning Problems	☐	☐	☐	☐
Menstrual Pain	☐	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	Schizophrenia	☐	☐	☐	☐
Chronic Pain	☐	☐	☐	☐	Bipolar Disorder	☐	☐	☐	☐
Stomach/Bowel Problems	☐	☐	☐	☐	Depression	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Sleep Disorder	☐	☐	☐	☐
Sexual Problems	☐	☐	☐	☐	Eating Disorder	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	Suicide Attempts/Thoughts	☐	☐	☐	☐

Additional Comments:

Smoking History (if applicable):

Do you smoke? ☐ Never ☒No ☐ Yes	Are you interested in smoking cessation information? ☐No ☐ Yes
If yes, how much do you smoke daily?	If you have smoked in the past, when did you quit?

Drug Allergies/Adverse Reactions

☐No known drug allergies/adverse reactions	Explain any drug allergies/adverse reactions:

Examination History:

Date of Last Physical Examination(approximately):	**Name of Physician last seen:**	**Phone # (if known):**

Address (if known) Include City, State and ZIP code:

Has client had hospitalizations in the last three years? ☐No ☐ Yes If YES, complete below:

Hospital:	**Date:**	**City:**	**Reason:**

Pregnancy History (if applicable)

Currently Pregnant? ☐No ☐Yes Last menstrual period? (date):	If YES, expected delivery date? Any significant pregnancy history? ☐No ☐Yes	**Pregnancy History Comments:**

Immunizations

Are you current on all of your immunizations? ☐No ☐Yes

Physical:

Height:

Weight:	Has client's weight changed in the past year? ☐No ☐Yes If YES, by how much (+ or -)?

Client's Current Medication (Prescription/OTC/Herbal)*

If you have a pre-printed med list please give it to the front desk to copy

☐ **None reported**

Current Medication	**Prescribed By**	**Starting Date**	**Total Daily Dosage**	**Reason**	**Compliance**	
					☐Yes	☐No
					☐Yes	☐No
					☐Yes	☐No

______________________	______________________	______________________
Signature of person completing form	**Relationship to client**	**Date**