BEHAVIORAL HEALTH AND MEDICAL HISTORY QUESTIONNAIRE

Client/Patient Name ______________________________ Date of Birth ______________

Accompanying Family Member/Significant Other (note relationship to person): ______________________________

____

1. Are you currently taking any medications (prescription, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)? No, go to question 2
Yes, answer questions I(a) – I(e) below

1(a) Identify the medications that you are currently taking for medical or behavioral health concerns and the reason for taking the medication below:

Name of Medication	Reason for Taking Medication
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

1(b) Have any of your medications been changed in the last month? No Yes, list the medications that have changed and explain why they were changed ______________________________

____

____

1(c) How long will your current supply of medications last? (How urgent is your need to obtain medications?)

____

1(d) Describe any side effects that you find troublesome from any of the medications you are currently taking.

____

____

1(e) Do you have any abnormal/unusual muscle movements? No Yes, how is it being treated?

____

2. Are you allergic to any medications? No Yes, which ones? ______________________________

3. Do you have any other allergies? No Yes, describe them ______________________________

4. When was the last time you saw your primary care physician/dentist and what was the purpose of that visit?

____

5. Do you have any history of head injury with concussion or loss of consciousness? No Yes, describe

____

6. Are you currently pregnant? No Yes Unsure

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BEHAVIORAL HEALTH AND MEDICAL HISTORY QUESTIONNAIRE

Client/Patient Name: ___________________________

7. Are there any medical problems that you currently receiving treatment for? No, go to question 8
Yes, answer 7(a) and 7(b) below

7(a) Describe below what current medical problems you have and what type of treatment you are currently receiving.

Medical Problem	Type of Treatment Receiving
______________________	______________________
______________________	______________________
______________________	______________________

7(b) Does your current medical condition(s) create problems in how you deal with life, including pain? No Yes, if yes explain: ____
____
____

8. Have you recently experienced any of the following?

Ear/Nose/Throat:

Severe dry mouth	No	Yes, when ______________________
Ear infections	No	Yes, when ______________________
Persistent sore throat	No	Yes, when ______________________

Respiratory System:

Respiratory infections	No	Yes, when ______________________
Persistent cough	No	Yes, when ______________________
Shortness of breath	No	Yes, when ______________________

Cardiovascular:

Chest pain	No	Yes, when ______________________
Swelling in legs, ankles, feet	No	Yes, when ______________________

Gastro-intestinal:

Persistent nausea / vomiting	No	Yes, when ______________________
Self-induced vomiting	No	Yes, when ______________________
Frequent or prolonged diarrhea / constipation	No	Yes, when ______________________
Excessive use of laxatives	No	Yes, when ______________________
Weight loss / gain	No	Yes, when ______________________
Blood in stools	No	Yes, when ______________________
Abdominal pain	No	Yes, when ______________________

Genitourinary:

Urinary discomfort	No	Yes, when ______________________
Frequent urination	No	Yes, when ______________________
Blood in urine	No	Yes, when ______________________

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Musculoskeletal:

Joint pain	No	Yes, when ____
Back pain	No	Yes, when ____

Neurological:

Facial or muscle twitching / jerking	No	Yes, when ____
Seizures	No	Yes, when ____
Passing out	No	Yes, when ____
Dizziness	No	Yes, when ____
Headaches	No	Yes, when ____

Infectious Diseases:

Sexually Transmitted Diseases	No	Yes, when ______________________ what ______________________________

Other:

Inappropriate defecation (bowel elimination)	No	Yes, when ____
Inappropriate bed wetting	No	Yes, when ____
Dry Skin	No	Yes, when ____
Hair loss	No	Yes, when ____
Unusual sweats or chills	No	Yes, when ____
Surgeries	No	Yes, when ______________________ what ______________________________
Problem with sleeping	No	Yes, indicate more or less sleep ____

Other conditions not listed above (signs and symptoms)

____
____
____
____

9. Do you use tobacco? No Yes, how much per day? ________ How long have you been using tobacco? _________ (yrs/mths)

10. Do you consume caffeine? No Yes, how many cups/cans do you drink per day? ________________

11. In total, how much fluid do you drink, i.e. how many cups/cans of total fluids do you drink per day? ______________

12. Have you ever received out-patient (office-based) services, been hospitalized or received services in a residential facility for behavioral health concerns? No, go to question 13
Yes, answer questions 12(a) – 12(c)

12(a) Describe below the type of treatment you received to address your behavioral health concerns and when you received this treatment

____	______________________________
Type of Treatment	When and Where Received
____	______________________________
Type of Treatment	When and Where Received
____	______________________________
Type of Treatment	When and Where Received
____	______________________________
Type of Treatment	When and Where Received

Client/Patient Name: __________________________

12(b) What current or prior treatment/services, including medication, do you think have been the most helpful in addressing your behavioral health symptoms? Explain: ____
____

12(c) What current of prior treatment /services, including medication, do you think have been the least helpful in addressing your behavioral health symptoms? Explain: ____
____

13. Describe any current or past behavioral health issues (including substance abuse) in your family. *(For purposes of this question, family may include birth family, adopted family, foster family and/or family person is or has lived with.)* _________________________________
____
____
____

If the person seeking behavioral health services was provided assistance in filling out this questionnaire, please provide the name/date of completion and telephone number of the individual providing this assistance.

Name (please print) ____ Date ____________________ Phone __________________