The COUNSELING CENTER of Wayne & Holmes Counties

Health History Questionnaire

Client Name_____ Date of Birth _____

Social Security Number_____ Gender: Male Female Other

Have you or an immediate family member had any of the following health problems? (Please check all that apply)

	Now	Past	Family		Now	Past	Family
AIDS/HIV				Head Injury/Brain Tumor			
Anemia				Headaches			
Arthritis				Hearing Problems/Deafness			
Asthma				Heart Disease			
Bleeding Disorder				Kidney Disease			
Blood Pressure (high or low)				Learning Problems			
Bone/Joint Problems				Lung Disease			
Cancer				Menstrual Problems			
Cirrhosis/Hepatitis (Liver Disease)				Sexual Problems			
Dental Problems				Sexual Transmitted Disease			
Diabetes				Sleep Problems/Disorder			
Eating Disorder				Speech Problems			
Epilepsy/Seizures				Stomach/Bowel Problems			
Eye Disease/Blindness				Stroke			
Fibromyalgia/Muscle Pain				Thyroid Problems			
Glaucoma				Tuberculosis			
Other:				Other:			

Treatment you received and the date(s) for health problems listed above:

Last Physical Examination

By Whom:	When:	Telephone:

Is this your family doctor? ☐ No ☐ Yes. If no, please list name and telephone of your primary care physician.

Current Medications

Name	Reason for Use	Name	Reason for Use

Have you had any medical hospitalizations/surgical procedures in the past three (3) years?
☐ No ☐ Yes. If yes, please complete information below.

Hospital	City, State	Date	Reason

Client Name_____ Client ID # _____

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Allergies/Drug Sensitivities	
☐ None	
☐ Food-Specify:	
☐ Medicine-Specify:	
☐ Other-Specify:	
Females Only-Pregnancy Status	**Children Only- Prenatal History**
Currently pregnant? ☐ No ☐ Yes. If yes, please answer the questions below: Expected due date? Receiving prenatal healthcare? ☐ No ☐ Yes. If yes, provider: Any complications with pregnancy? ☐ No ☐ Yes. If yes, explain.	Full-term birth? ☐ No ☐ Yes. If no, explain. Any Complications? ☐ No ☐ Yes. If yes, explain. Use during pregnancy: Alcohol? ☐ No ☐ Yes Drugs? ☐ No ☐ Yes Tobacco? ☐ No ☐ Yes Immunizations up-to-date? ☐ No ☐ Yes. If no, explain.

Height/Weight	
Height:	Has your height changed in the past year? ☐ No ☐ Yes. If yes, by how much (+ or-)?
Weight:	Has your weight changed in the past year? ☐ No ☐ Yes. If yes, by how much (+ or-)?

Nutritional Screening (Please check all that apply)					
☐ No problem	☐ Nausea ☐ Vomiting ☐ Trouble chewing/swallowing				
	☐ Special Diet-(Specify):				
Change in habits:	Eating: ☐ More ☐ Less ☐ Not eating	Drinking: ☐ More ☐ Less ☐ Takes Liquids only		Appetite: ☐ Increased ☐ Decreased	

Pain Screening
Do you suffer from any physical discomfort or pain ☐ No ☐ Yes. If yes, please describe:
If yes above, does pain currently interfere with your activities? ☐ No ☐ Yes. If yes, how much? ☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely

Substance Use
Caffeine Use? ☐ No ☐ Yes. If yes, type (coffee, tea, pop, energy drinks)?
How often used? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Tobacco Use? ☐ No ☐ Yes. If yes, type (cigarettes, cigars, chew)?
How often used? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Alcohol Use? ☐ No ☐ Yes. If yes, type (beer, wine, mixed drinks, etc.)?
How often used? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
Other Substance Use ☐ No ☐ Yes. If yes, type (Marijuana, Cocaine, Methamphetamines, etc.)?
How often used? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally

Client/Parent/Guardian Signature _____ Date _____

Client Name _____ Client ID # _____