psychbc

Health History Questionnaire

Date _____

Name _____ DOB _____

Please answer all questions with as much detail as possible, using the reverse side of this sheet as necessary. The more detailed the information, the better your treatment plan will be tailored to your own needs. Please remember ALL information you provide is protected with applicable confidentiality laws.

Please list: ALL prescription medications you are taking:

_____

_____

_____

ALL over-the-counter medications you take on a regular basis:

_____

_____

_____

Do you have any allergies? (If yes, please list)

_____

_____

Any herbal remedies you are using: _____

Any complimentary or alternative treatment you are using:

☐ Chiropractic ☐ Homeopathic

☐ Acupuncture ☐ other_____

Current Pharmacy: Name and Location _____

Phone _____

MENTAL HEALTH HISTORY

Do you or your immediate family (parents, grandparents, siblings, or children) have a history of any of the following? Please check the appropriate selection:

	Self		Family		
Depression	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Bipolar Disorder	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Anxiety	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Panic attacks	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Obsessive-Compulsive Disorder	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Post-Traumatic Stress Disorder	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
ADHD	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Sleep Problems	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Schizophrenia	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Eating disorder ☐ Anorexia ☐ Bulimia	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Borderline Personality Disorder	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Substance Use Disorders	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Dementias	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Other:	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown

Have you recently been under the care of another psychiatrist? ☐ No ☐ Yes

If yes, please provider name and phone number: _____

_____

Are you currently working with a therapist? ☐ No ☐ Yes

If yes, please provider name and phone number: _____

_____

Have you ever been hospitalized for mental health reasons? ☐ No ☐ Yes

If yes, please provider when and where: _____

_____

Have you been a victim of abuse? ☐ No ☐ Yes ☐ Current ☐ Past

If yes, please indicate type: ☐ Physical ☐ Sexual ☐ Emotional

If yes, have you received help? ☐ No ☐ Yes: _____

SUBSTANCE USE HISTORY

☐ No substance use currently or in the past

☐ No substance use currently or in the past except for Tobacco products

Tobacco Products: ☐ None ☐ Yes: ☐ Current ☐ Past

Daily quantity # _____ For how many years # _____

Alcohol: ☐ None ☐ Yes: ☐ Current ☐ Past

If yes: ☐ Beer ☐ Wine ☐ Liquor ☐ Other Daily quantity # _____

How many times per week? _____ For how long? _____

Any signs of withdrawal? ☐ None ☐ Yes Any signs of tolerance? ☐ None ☐ Yes

Have you ever experienced: ☐ Blackouts ☐ Seizures ☐ "The Shakes" (delirium tremors)

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

Cannabis: ☐ None ☐ Yes: ☐ Current ☐ Past

Daily quantity # _____ How many times per week? _____

Time of last use: _____ For how long? _____

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

Cocaine: ☐ None ☐ Yes: ☐ Current ☐ Past

Daily quantity # _____ How many times per week? _____

Time of last use: _____ For how long? _____

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

Any signs of withdrawal? ☐ None ☐ Yes Any signs of tolerance? ☐ None ☐ Yes

Stimulants: ☐ None ☐ Yes: ☐ Current ☐ Past

If yes, what kind (crystal meth, Ritalin, etc..)? _____

Daily quantity # _____ How many times per week? _____

Time of last use: _____ For how long? _____

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

Any signs of withdrawal? ☐ None ☐ Yes Any signs of tolerance? ☐ None ☐ Yes

Opiates: ☐ None ☐ Yes: ☐ Current ☐ Past

If yes, what kind (heroin, pain pills, etc..)? _____

Daily quantity # _____ How many times per week? _____

Time of last use: _____ For how long? _____

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

Any signs of withdrawal? ☐ None ☐ Yes Any signs of tolerance? ☐ None ☐ Yes

Prescription Pills: ☐ None ☐ Yes: ☐ Current ☐ Past

If yes, what kind (Valium, Xanax, etc..)? _____

Daily quantity # _____ How many times per week? _____

Time of last use: _____ For how long? _____

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

Any signs of withdrawal? ☐ None ☐ Yes Any signs of tolerance? ☐ None ☐ Yes

Inhalants: ☐ None ☐ Yes: ☐ Current ☐ Past

Daily quantity # _____ How many times per week? _____

Time of last use: _____ For how long? _____

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

PCP: ☐ None ☐ Yes: ☐ Current ☐ Past

Daily quantity # _____ How many times per week? _____

Time of last use: _____ For how long? _____

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

LSD: ☐ None ☐ Yes: ☐ Current ☐ Past

Daily quantity # _____ How many times per week? _____

Time of last use: _____ For how long? _____

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

Ecstasy: ☐ None ☐ Yes: ☐ Current ☐ Past

Daily quantity # _____ How many times per week? _____

Time of last use: _____ For how long? _____

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

Other: _____ ☐ None ☐ Yes: ☐ Current ☐ Past

Daily quantity # _____ How many times per week? _____

Time of last use: _____ For how long? _____

Days sober in past month: ___ Months sober in past year: ___ Longest sobriety: _____

Consequences of Substance Use:

☐ Social Impairment ☐ Occupational Impairment

☐ Legal Problems ☐ Medical Problems

Have you ever attempted to quit on your own? ☐ None ☐ Yes ☐ Current ☐ Past

If yes, please provide details: _____

_____

Have you ever been to Outpatient substance use treatment? ☐ None ☐ Yes ☐ Current ☐ Past

If yes, please provide details: _____

_____

Have you ever been to inpatient substance use treatment? ☐ None ☐ Yes ☐ Current ☐ Past

If yes, please provide details: _____

_____

Have you ever been to AA or other self-help groups? ☐ None ☐ Yes ☐ Current ☐ Past

If yes, please provide details: _____

_____

GENERAL HEALTH HISTORY

Do you or your immediate family (parents, grandparents, siblings, or children) have a history of any of the following? Please check the appropriate selection

	Self				Family		
Diabetes	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
High Cholesterol	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
Thyroid Condition	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes: ☐ Overactive ☐ Underactive							
High Blood Pressure	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
Heart Attack	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
Migraine Headaches	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
Tension Headaches	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
Sinus Problems	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
Stroke	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown

	Self				Family		
Seizure Disorder	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
Head Trauma	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
Confusion	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
Memory Loss	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
HIV	☐ No	☐ Yes:	AIDS?	☐ No ☐ Yes	☐ No	☐ Yes	☐ Unknown
Hepatitis	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, what kind: ☐ A ☐ B ☐ C							
STD	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, what kind: _____							
Cancer	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, explain: _____							
Respiratory (Lung) Problems	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, explain: _____							
Heart Problems	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, explain: _____							
Stomach Problems	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, explain: _____							
Bowel Problems	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, explain: _____							
Kidney/Bladder Problems	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, explain: _____							
Neurological Problems	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, explain: _____							
Vision Problems	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, explain: _____							
Hearing Problems	☐ No	☐ Yes:	☐ Current	☐ Past	☐ No	☐ Yes	☐ Unknown
If yes, explain: _____							

Are currently under the care of a primary care physician? ☐ No ☐ Yes

If yes, please provider name and phone number: _____

_____

Last Physical Exam: _____ Last Tetanus Shot: _____

Have you ever had surgeries? ☐ No ☐ Yes

If yes, please list type and date: _____

_____

Have you ever had blood transfusion?

If yes, please list type and date: _____

_____

Have you ever shared needles? ☐ No ☐ Yes: ☐ Current ☐ Past

Female patients:

Last PAP test: _____ Last Period: _____

Number of Pregnancies: _____ Number of Living Children: _____

What type of birth control do you use? _____

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

Provider Signature _____Date _____