Comprehend, Inc.
Your Community Source for Mental Wellness

PHYSICAL HEALTH STATUS QUESTIONNAIRE

Client Name: _____ **ID Number:** _____

HISTORY OF MEDICAL PROBLEMS: Please check the appropriate box. If "yes", please describe in the space provided.
Are you being treated, or have you ever had any of the following problems?
If "yes", please explain the nature of the problem, dates, and treatment in the space provided.

YES NO

☐ ☐ Problems with eyes, ears, nose or throat? _____
_____

☐ ☐ Dizziness, fainting, headache, fatigue, seizures, head injuries? _____
_____

☐ ☐ Chest pains, high blood pressure, heart attack, stroke or other heart disorders, blood disorders or hardening of the arteries? _____
_____

☐ ☐ Cough, shortness of breath, asthma, chronic obstructive pulmonary disease or other respiratory problems?_____

☐ ☐ Ulcers or other stomach or bowel symptoms? _____
_____

☐ ☐ Diabetes, thyroid, pancreas, liver, or jaundice problems? _____
_____

☐ ☐ Disorder of muscles, bones, back or joint arthritis? _____
_____

☐ ☐ Any allergies (plants, animal, food, etc.)? _____
_____

☐ ☐ Are you pregnant? If yes, did you receive prenatal care? _____
_____

☐ ☐ Any problems with pregnancy? _____
_____

☐ ☐ Infectious diseases (tuberculosis, hepatitis, AIDS, etc.)? _____
_____

☐ ☐ Do you drink alcohol or use non-prescription drugs / street drugs? (Give frequency, amount, and duration of use) _____
_____

☐ ☐ History of cancer or severe infections?_____
_____

Name / ID Number: _____

☐ ☐ Are immunizations up to date? _____

_____

☐ ☐ Do you smoke tobacco? How many packs per day? _____

MEDICATIONS PROFILE

List all over-the-counter medications, herbal remedies and all prescription medication you are currently or have been taking.

Medicine	Dosage	How Often?	For How Long?

Are you allergic to any medications or ever had a reaction to any medications?
If "yes", what was the medication and what was the reaction?

_____

What gender were you at birth? ☐ Male ☐ Female

Optional: With what gender do you identify? ☐ Male ☐ Female

Optional: Do you consider yourself to be: ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual
Other:

Do we have your consent to communicate & provide information to your Personal Care Physician including substance usage? ☐ Yes ☐ No

I authorize and give this consent voluntarily. I have been informed of the specific type of information that has been requested and the benefits and disadvantages of releasing that information has been explained to me. I understand that the provision of services is not contingent on my decision concerning this release of information.

Current Primary Physician: _____ **Phone:** _____

Client Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____