Health Questionnaire

Name: _____ Date: _____
Age: _____ Date of Birth: _____ Height: _____ Weight: _____
Primary Care Physician: _____
Dr. Address & Phone: _____

When was your last medical exam? _____
How would you rate your present health? ____ Good ____ Fair ____ Poor
List any medical conditions that you have: _____
_____
Name of the physician monitoring this condition(s): _____
List any medications that you are currently taking: _____
_____
Who prescribes these medications to you? _____

Have you seen a psychiatrist or counselor before? Yes ____ No ____ When? _____
Please explain: _____
_____
Have you ever had an accident? ___ Head Injury? _____

When do you go to bed? _____ What grade are you in/level of education?_____
do you like school?_____ Did you/do you have any significant relationships?__

Check any of the following problems that you experience:

____ Lack of appetite	____ Frequent Colds/flu	____ Bladder control
____ Appetite Change	____ Stomach problems	____ Bowel problems
____ Nervousness	____ Fatigue	____ Anxiety
____ Fears/phobias	____ Obsessive thoughts	____ Compulsive behaviors
____ Panic attacks	____ Confusion	____ Nightmares
____ Intrusive thoughts	____ Sleep disturbance	____ Difficulty concentrating
____ Flashbacks	____ Depression	____ Feelings of unreality
____ Headaches	____ Difficulty relaxing	____ Pain

____ Other health concerns: _____
Any Parent History of above: _____

Concussions_____ Loss of Consciousness _____

Clinician Use Only

Notes:

Referrals Made:

Follow-up needed: