*HA.L.O. Educational Systems, LLC.*

**Health Questionnaire**

(603) 523-8804

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? do you like school?

What grade are you in/level of education?

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:

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