Health Questionnaire

Name: Date:
Primary Care Physician:
Dr. Address & Phone:
When was your last medical exam?
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How would you rate your present health? Good Fair Poor
List any medical conditions that you have:
None of the above in a great rice while a goal time (a)
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
Intrusive thoughts Sleep disturbance Difficulty concentrating Depression Feelings of unreality
Headaches Difficulty relaxing Pain
Other health concerns:
Any Parent History of above:
Concussions Loss of Consciousness
Clinician Use Only
Notes:
Deferrale Made
Referrals Made:
Follow-up needed: