NAME: _____ **DOB:** _____

MEDICAL HISTORY QUESTIONNAIRE

1. Are you currently taking any **medications** (prescriptions, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)? ☐ No, go to question 2.
   ☐ Yes, answer questions 1(a) – 1(e) below

1(a) Identify the medications that you are currently taking for medical or behavioral health concerns and the reason for taking the medications below, **including OTC vitamins, minerals, dietary and herbal supplements.**

Name of Medication or supplement	Dose	Reason for Taking	Prescribed and supervised by

Have any of your medications been changed in the last 30 days? ☐ No ☐ Yes, list the medications and what changes have been made: _____

_____

2. Are you **allergic** to any medications? ☐ No ☐ Yes, which ones? _____

3. Do you have any other **allergies**? ☐ No ☐ Yes, describe them: _____

4. When was the last time you saw your **primary care physician/dentist?** _____

   Reason for visit? _____

5. Do you have any history of **head injury** with concussion or loss of consciousness? ☐ No ☐ Yes, how was it treated?

   Include date(s) and description _____

6. Are you currently **pregnant?** ☐ No ☐ Yes ☐ Unsure How many children do you have?_____ ☐ None

   Number of live births_____ ☐ None Abortions_____ ☐ None Miscarriages / stillborn_____ ☐ None

7. Are there any **medical problems** that you are currently receiving treatment for? ☐ No, go to question 8.
   ☐ Yes, answer 7(a) and 7(b) below

7(a) Describe below what current medical problems you have and what type of treatment you are currently receiving:

Medical Problem	Type of Treatment Receiving

7(b) Does your current medical condition(s) create **chronic pain**? ☐ No (If no, go to question 8) ☐ Yes: Please circle average

0 1 2 3 4 5
No pain — Moderate Pain — Worst possible pain

Location (e.g. headache): _____

Quality (e.g. burning, sharp, throbbing, dull): _____

When does it occur? _____

How long does it last? _____

How does it affect your functioning (e.g. can't sit, walk, work out)? _____

_____

NAME: _____ **DOB:** _____

8. Do you use **tobacco?** ☐ No ☐ Yes #____ per day. ☐ Never smoked. ☐ Former smoker: yr started_____ yr stopped_____

9. Do you consume **caffeine?** ☐ No ☐ Yes, how many cups/cans? _____ per day

10. In total, how much **fluid** do you drink per day? (total oz or # cups) _____

11a. Do you consume **alcohol**? ☐ No ☐ Yes, how often? ☐ 1-2x/wk ☐ 3-4x/week ☐ 5+x/week. # drinks per day_____

Date last used_____ Amount_____ Age of first use_____ ☐ Never used

11b. Do you use **marijuana**? ☐ No ☐ Yes, how often? ☐ 1-2x/wk ☐ 3-4x/week ☐ 5+x/week. Amount per day_____

Date last used_____ Amount_____ Age of first use_____ ☐ Never used

11c. Do you use **other substances (drugs)** ☐ No ☐ Yes, how often? ☐ 1-2x/wk ☐ 3-4x/week ☐ 5+x/week

Date last used_____ Amount_____ Age of first use_____ ☐ Never used

11d. Do you engage in **behaviors** such as gambling, compulsive spending or eating_____

Last time_____ How often_____ Age of onset_____ ☐ Never

Past Surgeries ☐ No ☐ Yes, please describe below:

Date	Description

BEHAVIORAL HEALTH HISTORY

13. Have you ever received **out-patient** (office-based) **services**, been **hospitalized** or received services in a **residential facility** for **behavioral health concerns**? ☐ No, go to question 14. ☐ Yes, answer questions 13(a) – 13(c)

13(a) Describe below the type of treatment you received to address your behavioral health concerns and when you received treatment:

Type of Treatment	When and Where Received

13(b) What current or prior treatment/services, including medications, do you think have been most helpful in addressing your behavioral health symptoms? Explain: _____

_____

13(c) What current or prior treatment/services, including medications, do you think have been least helpful in addressing your behavioral health symptoms? Explain: _____

_____

14. Describe any current or past **substance abuse in your family** (*For purposes of this question, "family" may include birth family, foster family and/or family with whom person is or has lived.*

Family Member	Current (Y/N)	Past (Y/N)	Description

15. Family history of **mental health** concerns (e.g. depression, anxiety, bipolar, schizophrenia, OCD, PTSD)

Family Member	Current (Y/N)	Past (Y/N)	Description