Health History Questionnaire

Name: _____ **Today's date:** _____

DOB: _____ **Age:** _____

Reason for seeking counseling:_____

_____

Primary Care Physician: _____ **Phone:** _____

Symptoms: Check all symptoms you currently have, or have had during the past 12 months:

___anger
___anxiety
___aggressive behavior
___attention problems
___compulsive behavior
___depression
___disorganization
___eating problems
___obsessive thinking
___flashbacks
___headache
___impulsive behavior
___irritability
___learning problems
___negativity
___procrastination
___worry
___stress
___perfectionism
___panic
___seasonal mood changes
___fears and phobias
___ moodiness

other _____

Physical Symptoms: Check all symptoms you currently have, or have had during the past 12 months:

___asthma
___bleeding
___breathing problems
___constipation
___diarrhea
___joint pain
___visual changes
___bruising
___chest pains
___muscle pain
___stomach pains
___passing out
___dizziness
___weakness
___hearing problems
___high blood pressure
___involuntary movements
___irregular heart beat
___fevers
___seizures
other_____

Conditions: Please list any physical conditions:

_____

_____

_____

Medications: Please list all prescription and non-prescription medications:

1. _____ 3. _____

2. _____ 4. _____

Married/Partner status: ___ **single** ___ **partnered** ___ **divorced** ___ **widowed**

Children? **Age** **Health Status** **Grade (if applicable)**

Occupation _____

Primary Sources of Occupational Stress (if any):

_____

_____

Health Habits

Do you exercise regularly? ____yes ____ no

What type of exercise? _____

Date of last physical exam? _____

Do you use alcohol?_____ tobacco?_____ drugs_____ caffeine?_____

Family History: Please check any condition present in a blood relative:

___ alcoholism ___ abuse ___ bipolar disorder ___ trauma

___ depression ___ anxiety ___violence ___ obsessive compulsive disorder

___ attention deficit disorder ___ psychosis ___ suicide

Family Health Status:

	Age	Health	Quality of Relationship
Father			
Mother			
Brother(s)			
Sister(s)			

Mental Health History

Hospitalizations _____

Prior psychotherapy _____

Prior psychiatric care _____

Serious illness or injury _____

Medical conditions _____

Surgeries _____

I certify that the above information is correct to the best of my knowledge and that I have not purposefully misrepresented my health or mental health history. I will not hold Linda Esposito, LCSW responsible for errors or omissions that I may have made in completing this form.

_____ _____

Signature Date