Medical History Questionnaire

Complete the following questionnaire to provide a detailed account of your health status. This will contribute to the development of your treatment program.

Name: _____ _____ _____
First MI Last

DOB: _____ Place of Birth: _____
MM/DD/YYYY State/Country

Please give the reason for your visit today:

_____

_____

Please describe any symptoms you are experiencing:

_____

_____

_____

Psychiatric History:

Previous Diagnoses: _____

Previous Medications: _____

_____

Previous Psychiatric Hospitalizations: (please provide dates, locations, reasons hospitalized)

_____

_____

_____

Have you ever tried to hurt yourself?: (Please describe)_____

_____

Are you currently having any thoughts of self harm? (circle) Yes No

Substance Use: (please put N/A if never used)

Age of first use of alcohol: _____

If currently using, how much/often?: _____

Age of first use of tobacco: (cigarettes, chew, vape) _____

If currently using, how much/often?:_____

Age of first use of marijuana: _____

If currently using, how much/often?: _____

Please indicate use and first age of use, if any, of the following :

□Cocaine _____ □ LSD _____ □ Heroin _____ □ PCP _____

□ Speed/Meth _____ □ DXM_____ □ Pain pills _____ □ Sedatives_____

Please list any other substances you have used that are not provided above: (e.g. steroids, bath salts, Kratom, opium, K2/Spice, etc…)

_____

_____

Which substances have been problematic and why?: (e.g. DUI, legal charges, medical complications – HIV, Hepatitis, job, family, financial losses, etc…)

_____

_____

_____

Family Psychiatric/Substance Use History: (any diagnoses, treatments, suicidality, drug/alcohol)

_____

_____

_____

Medical History:

Please check or circle any current medical problems:

Seizures	Cancer	Emphysema	Diabetes	Heart Disease
Tumors	Anemia	Tuberculosis	Asthma	Kidney Problems
Glaucoma	Ulcers	Pancreatitis	Arthritis	High Blood Pressure
Cirrhosis	HIV/AIDS	Rheumatic fever	PMS	Venereal Disease

Please list any other medical problems not above: _____

_____

Please check or circle any current physical/medical symptoms:

Headaches	Dizziness	Stomach Pain	Tremors	Diarrhea
Fainting	Nausea	Constipation	Vomiting	Burry Vision
Chest Pain	Cramps	Palpitations	Cough	Muscle Spasm

Please list any other physical/medical symptoms not above: _____

_____

FOR WOMEN: Date of last menstrual period _____ Any chance you are pregnant now? _____

Medications: (taking currently)

Name: _____ Dose _____ How long taking: _____

Name: _____ Dose _____ How long taking: _____

Name: _____ Dose _____ How long taking: _____

Name: _____ Dose _____ How long taking: _____

Name: _____ Dose _____ How long taking: _____

Medical Hospitalizations or Surgeries: **(please include date, location, reason)**

_____
_____
_____
_____

Allergies: **(foods, medications, seasonal)**

_____
_____

Life Experiences: **(any recent changes in the last year – marital, children, job, deaths, abuse, diet, moving, financial, school, legal, etc…)**

What are your goals of treatment? What does feeling/doing better look like to you? What are you hoping to be able to do when you are better? Please write down any other information you feel we should be aware of.

Patient Signature: _____

DATE: _____