COUNTY OF HUMBOLDT
Department of Health and Human Services
Behavioral Health
1028—Health History Questionnaire

Client First Name _____ Client Last Name _____

Client ID _____ Date of Service _____

Allergies: Do you have allergies to, or have reacted adversely to, any of the following items?

☐ Local anesthesia or dental anesthetics ☐ Penicillin ☐ Sulfa drugs
☐ Barbiturates, sedatives or sleeping pills ☐ Other antibiotics ☐ Iodine
☐ Aspirin
☐ Allergies/reactions to any other drugs or food: please list _____
☐ **No Known Allergies**

Current Physical Health (client) is: ☐ Good ☐ Poor Has changed in past year? ☐ Yes ☐ No

Do you have or have you ever had any of the following medical conditions?

☐ Allergies
☐ Anemia
☐ Arterial Sclerotic Disease
☐ Arthritis
☐ Asthma
☐ Birth Defects
☐ Blind/Visual Impairment
☐ Cancer: _____
☐ Carpal Tunnel Syndrome
☐ Chronic Lung Disorder
☐ Chronic Pain
☐ Cirrhosis
☐ Congestive Heart Failure
☐ Cystic Fibrosis
☐ Deaf/Hearing Impairment
☐ Diabetes
☐ Digestive Disorders (Reflux, Irritable Bowel Syndrome, Colitis)
☐ Ear Infections
☐ Epilepsy/Seizures
☐ Head Injury
☐ Heart Disease
☐ Hepatitis/Jaundice
☐ Hypercholesterolemia
☐ Hyperlipidemia
☐ Hypertension (High Blood Pressure)
☐ Hyperthyroidism
☐ HIV
☐ Infertility
☐ Meningitis
☐ Migraines
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Obesity
☐ Osteoporosis
☐ Other Neurological
☐ Parkinson's Disease
☐ Physical Disability
☐ Psoriasis
☐ Rheumatic Fever
☐ Sexually Transmitted Infection
☐ Stroke
☐ Tinnitus
☐ Tuberculosis
☐ Ulcers
☐ Other _____

Comments: _____

_____

WOMEN ONLY:

Are you currently pregnant? ☐ Yes ☐ No ☐ Don't know Last menstrual cycle: _____

Have you ever had any of the following problems?

- ☐ Eye disease, injury, or impaired sight
- ☐ Ear disease, injury, or impaired hearing
- ☐ Loss of consciousness
- ☐ Fainting spells
- ☐ Convulsions
- ☐ Paralysis
- ☐ Dizziness
- ☐ Frequent or severe headaches
- ☐ Trouble with nose, sinuses, mouth, or throat
- ☐ Enlarged thyroid or goiter
- ☐ Enlarged glands
- ☐ Loss of appetite
- ☐ Extreme tiredness or weakness
- ☐ Skin disease
- ☐ Chronic or frequent cough
- ☐ Chest pain or angina
- ☐ Coughing up blood
- ☐ Night sweats
- ☐ Varicose veins
- ☐ Shortness of breath
- ☐ Palpitations/fluttering heart
- ☐ Back, arm, or leg problems
- ☐ Kidney disease or stones
- ☐ Bladder disease
- ☐ Swelling of hands, feet, or ankles
- ☐ Protein, sugar, blood in urine
- ☐ Difficulty urinating
- ☐ Abnormal thirst
- ☐ Frequent urination
- ☐ Indigestion
- ☐ Depression or anxiety
- ☐ Suicidal thoughts
- ☐ Memory problems
- ☐ Difficulty concentrating
- ☐ Hallucinations
- ☐ Crying spells
- ☐ Appendicitis
- ☐ Liver or gallbladder disease
- ☐ Hemorrhoids/rectal bleeding
- ☐ Constipation or diarrhea
- ☐ Other:

Are you currently under the care of a primary health care provider (for example, doctor, nurse practitioner, clinic)?

☐ Yes ☐ No Condition for which you receive treatment _____

Current primary health care provider's name _____

Current primary health care provider's address _____

Date of last physical exam _____

Authorization for Release of Information signed to allow sharing of information? ☐ Yes ☐ No

Family History: Has anyone in your immediate family had any of the following illnesses?

☐ Diabetes ☐ Cancer ☐ Heart disease ☐ Overweight ☐ Stroke

☐ High blood pressure ☐ Seizure ☐ Other neurological disorder: _____

Additional information, other significant illnesses, etc.: _____

Personal History: Please check and explain as appropriate if you have any history of treatment for the following illnesses listed below:

☐ Depression ☐ Schizophrenia ☐ Bipolar ☐ Substance Use ☐ Suicide Attempt

☐ Other: _____

Treatment history:

Number of psychiatric hospitalizations (*best estimate*) for self in: ___Past year ___Past 5 years ___Lifetime

Family History: Please check and explain if there is any history of treatment for your family members:

Parent:	☐ Depression	☐ Schizophrenia	☐ Bipolar	☐ Substance Use	☐ Suicide Attempt	☐ Other
Sibling:	☐ Depression	☐ Schizophrenia	☐ Bipolar	☐ Substance Use	☐ Suicide Attempt	☐ Other
Child:	☐ Depression	☐ Schizophrenia	☐ Bipolar	☐ Substance Use	☐ Suicide Attempt	☐ Other
Aunt/Uncle:	☐ Depression	☐ Schizophrenia	☐ Bipolar	☐ Substance Use	☐ Suicide Attempt	☐ Other
Grandparent:	☐ Depression	☐ Schizophrenia	☐ Bipolar	☐ Substance Use	☐ Suicide Attempt	☐ Other

If Other, please specify: _____

Medication History: Please provide medications for the past two years. Record the highest dose given.

Medication	Currently taking?	Dose	Frequency	Start/Stop Dates	Prescribed By	How effective are these medications at treating your symptoms?	Well tolerated?
1.	☐Yes ☐No					☐Full ☐Partial ☐Minimal ☐None	☐Yes ☐No
2.	☐Yes ☐No					☐Full ☐Partial ☐Minimal ☐None	☐Yes ☐No
3.	☐Yes ☐No					☐Full ☐Partial ☐Minimal ☐None	☐Yes ☐No
4.	☐Yes ☐No					☐Full ☐Partial ☐Minimal ☐None	☐Yes ☐No
5.	☐Yes ☐No					☐Full ☐Partial ☐Minimal ☐None	☐Yes ☐No
6.	☐Yes ☐No					☐Full ☐Partial ☐Minimal ☐None	☐Yes ☐No
7.	☐Yes ☐No					☐Full ☐Partial ☐Minimal ☐None	☐Yes ☐No
8.	☐Yes ☐No					☐Full ☐Partial ☐Minimal ☐None	☐Yes ☐No
9.	☐Yes ☐No					☐Full ☐Partial ☐Minimal ☐None	☐Yes ☐No
10.	☐Yes ☐No					☐Full ☐Partial ☐Minimal ☐None	☐Yes ☐No

Comments: Please make additional comments if needed to clarify.

Client Signature: _____ Date: _____
Guardian Signature: _____ Date: _____
Staff Signature: _____ Date: _____

MD REVIEW (if client has been reviewed to Medication Support):

MD Signature: _____ Date: _____