PART A: BEHAVIORAL HEALTH AND MEDICAL HISTORY QUESTIONNAIRE

Name______________________________ Date of Birth__________ Client CIS ID#__________
(to be filled in by provider)

Accompanying Family Member/Significant Other (note relationship to person):______________________________

1. Are you currently taking any **medications** (prescription, 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:

Name of Medication	Reason for Taking Medication

1(b) Have any of your medications been changed in the last month? ☐ No ☐ Yes, list the medications that have changed and explain why they were changed.______________________________

1(c) How long will your current supply of medications last? (How urgent is your need to obtain medications?)__________

1(d) Describe any side effects that you find troublesome from any of the medications you are currently taking.__________

1(e) Do you have any abnormal/unusual muscle movements? ☐ No ☐ Yes, how is it being treated?__________

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** and what was the purpose of that visit?__________

5. Do you have any history of **head injury** with concussion or loss of consciousness? ☐ No ☐ Yes, describe.__________

6. Are you currently **pregnant**? ☐ No ☐ Yes ☐ Unsure

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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 problems in how you deal with life, including pain? ☐ No ☐ Yes, if yes explain.________________

8. Have you recently experienced any of the following?

Ear/Nose/Throat:

Severe dry mouth	☐ No ☐ Yes, when ________
Ear infections	☐ No ☐ Yes, when ________
Persistent sore throat	☐ No ☐ Yes, when ________

Respiratory System:

Respiratory infections	☐ No ☐ Yes, when ________
Persistent cough	☐ No ☐ Yes, when ________
Shortness of breath	☐ No ☐ Yes, when ________

Cardiovascular:

Chest pain	☐ No ☐ Yes, where ________
Swelling in legs, ankles, feet	☐ No ☐ Yes, where ________

Gastro-intestinal:

Persistent nausea / vomiting	☐ No ☐ Yes, when ________
Self-induced vomiting	☐ No ☐ Yes, when ________
Frequent or prolonged diarrhea / constipation	☐ No ☐ Yes, when ________
Excessive use of laxatives	☐ No ☐ Yes, when ________
Weight loss / gain	☐ No ☐ Yes, when ________
Blood in stools	☐ No ☐ Yes, when ________
Abdominal pain	☐ No ☐ Yes, when ________

Genitourinary:

Urinary discomfort	☐ No ☐ Yes, when ________
Frequent urination	☐ No ☐ Yes
Blood in urine	☐ No ☐ Yes, when ________

Musculoskeletal:

Joint pain	☐ No ☐ Yes, when ________
Back pain	☐ No ☐ Yes, when ________

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Neurological:

Facial or muscle twitching/jerking ☐ No ☐ Yes, when __________
Seizures ☐ No ☐ Yes, when __________
Passing out ☐ No ☐ Yes, when __________
Dizziness ☐ No ☐ Yes, when __________
Headaches ☐ No ☐ Yes, when __________

Infectious Diseases:

Sexually Transmitted Diseases ☐ No ☐ Yes, when __________ what __________

Other:

Inappropriate defecation (bowel elimination) ☐ No ☐ Yes, when __________
Inappropriate bed wetting ☐ No ☐ Yes, when __________
Dry skin ☐ No ☐ Yes, when __________
Hair loss ☐ No ☐ Yes, when __________
Unusual sweats or chills ☐ No ☐ Yes, when __________
Surgeries ☐ No ☐ Yes, when __________ what __________
Problem with sleeping ☐ No ☐ Yes, indicate more or less sleep __________

Other conditions not listed above (signs and symptoms)

____

9. Do you use **tobacco**? ☐ No ☐ Yes, how much per day?______ How long have you been using tobacco?______ (yrs/mths)

10. Do you consume **caffeine**? ☐ No ☐ Yes, how many cups/cans do you drink per day?________

11. In total, how much **fluid** do you drink, i.e., how many cups/cans of total fluids do you drink per day? ________

12. 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 13.
☐ Yes, answer questions 12(a) – 12(c).

12(a) Describe below the type of treatment you received to address your behavioral health concerns and when you received this treatment.

Type of Treatment	When and Where Received

12(b) What current or prior treatment/services, including medication, do you think have been the <u>most helpful</u> in addressing your behavioral health symptoms? Explain ____________________

12(c) What current or prior treatment/services, including medication, do you think have been the <u>least helpful</u> in addressing your behavioral health symptoms? Explain ____________________

 Name:____________________

13. Describe any current or past **behavioral health issues** (including substance abuse) in your **family.** (*For purposes of this question family may include birth family, adopted family, foster family and/or family person is or has lived with.*)____________________

If the person seeking behavioral health services was provided assistance in filling out this questionnaire, please provide the name,date of completion and telephone number of the individual providing this assistance.

Name (please print)____________________ Date____________ Phone________________