Actively Engaging in your Journey of Creating Balance LLC

Client Name _____

D.O.B. _____

Today's Date: _____

Health History Questionnaire

1. Please list all current medications and dosages _____
   _____
2. Allergy _____
3. Rate your general health today 1 _____10
   Awful Great
4. Check any concerns that apply:

__ anxiety/stress	__ cancer	__ depression	__ self esteem
__ headaches	__ weight/body	__ friends or lack of	__ family
__ drugs	__ anger	__ sleep	__ STD/HIV/AIDS
__ fatigue	__ school/academic	__ employment	__ nightmares
__ pregnancy	__ future	__ grief/loss	__ place to live
__ stomach aches	__ dizzy/fainting	__ muscle/joint pain	__ earaches
__ sore throats	__ coughing/asthma	__ vomiting	__ diarrhea
__ back trouble	__ arthritis	__ high blood pressure	__ chronic pain
__ diabetes	__ epilepsy/seizures	__ fibromyalgia	__ constipation
__ sexual	__ hay fever/allergies	__ heart problems	__ irritable bowel
__ skin problems	__ hearing or vision	__ privacy	__ boredom
__ abuse	__ birth control	__ bullying	__ faith
__ death	__ nutrition/diet	__ exercise	__ dating
__ communication	__ menstruation	__ masturbation	__ safety/risk

   Smoker/Chew/amount per day_____, Caffeine _____, Gambling ____, Pornography ___
   __ other(s) _____
   Family history of the above conditions_____
5. Medical Doctor: _____ Last seen: _____
   Currently being treated Yes No Treated for _____
6. Prior outpatient therapy? Please list therapist, reason and date _____
   _____
7. Prior inpatient mental health. Please list hospitals and dates _____
   _____
8. Prior substance abuse treatment. Please list Programs and dates _____
   _____
9. List any family members with substance abuse or mental health issues _____
   _____