HEALTH HISTORY QUESTIONNAIRE

North Star Counseling Services, LLC
Germantown, WI

Name _____

1. Please list all current medications you are taking for either physical or emotional difficulties.

_____

2. Allergies to medications: _____

3. Current medical/emotional conditions (please check):

___ Anxiety	___ Depression	___ Heart problems	___ Other (please list)
___ Allergies	___ Diabetes	___ Irritable bowels	_____
___ Asthma	___ Epilepsy/seizure disorder	___ Sexually transmitted disease	_____
___ Arthritis	___ Fatigue	___ Skin problems	_____
___ Back trouble	___ Frequent constipation	___ Sleep disturbance	_____
___ Hypertension	___ Frequent headaches	___ Stomach problems	_____
___ Cancer	___ Hay fever	___ Vision problems	_____
___ Chronic pain	___ Hearing problems	___ Weight loss	_____

Is there any family history of the above conditions? _____

4. Medical doctor: _____

Are you currently being treated? _____ Problem: _____

Date last seen: _____

5. Have you ever been seen for outpatient therapy? Please list previous therapists and reasons seen.

_____

Have you ever been hospitalized for emotional difficulties? Please list hospitals & approximate dates.

_____

Have you ever been treated for chemical dependency? Please list hospitals and approximate dates.

_____

6. Do any family members have chemical dependency, alcoholism, or emotional problems? Please list.

_____

7. Do you use sedatives, alcohol, tobacco, laxatives, caffeine? (Please circle)

Amounts per day: _____

_____

8. Are you having problems in your sexual relationship? _____ If so, describe: _____

_____

_____