Green Road Behavioral Health

Thomas A. Boyd, Psy.D.

Health History Questionnaire

Date: _____

Name: _____ DOB: _____ Age: ____

Please answer all questions with as much detail as possible, using the reverse side of a page as necessary. ALL of the information you provide is protected under applicable confidentiality laws.

❖ **Please list ALL prescription medications you are taking:**

Medication	Dosage	Frequency	Prescribing Doctor	Reason for Taking

❖ **Please list ALL over-the-counter medications you take on a regular basis:**

OTC Medication	Dosage	Frequency	Prescribing Doctor	Reason for Taking

Health History Questionnaire

❖ **Please list ANY herbal remedies or supplements you are using and the reason you are doing so:**

_____

_____

_____

❖ **Please check ANY complimentary or alternative treatment(s) you are receiving:**

☐ Chiropractic ☐ Homeopathic ☐ Acupuncture ☐ Massage

☐ Other: _____

MENTAL HEALTH HISTORY

❖ **Please check the appropriate boxes to indicate whether or not you or an immediate family member (parent, grandparents, siblings, or children) have a history of any of the following conditions:**

Condition	Self		Family		
Depression	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Bipolar Disorder	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Anxiety	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Panic attacks	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Obsessive-Compulsive Disorder	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Post-Traumatic Stress Disorder	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
ADHD	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Sleep Problems	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Schizophrenia	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Eating disorder ☐ Anorexia ☐ Bulimia	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Borderline Personality Disorder	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Other Personality Disorder	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Substance Use Disorders	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Dementias	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown
Other:	☐ No	☐ Yes	☐ No	☐ Yes	☐ Unknown

Health History Questionnaire

❖ **Have you ever been hospitalized for mental health reasons?** ☐ Yes ☐ No

If YES, please provide when and where this occurred: _____

_____

_____

❖ **Please list any Past or Present mental health providers you have seen:**

Name, Degree	Address	Phone No.	Dates	Is This Current"
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

❖ **Have you ever been the victim of abuse?** ☐ Yes ☐ No ☐ Current ☐ Past

If YES, please indicate the type of abuse: ☐ Physical ☐ Sexual ☐ Emotional

If YES, was the abuse reported: ☐ Yes ☐ No **If YES, did you receive help?** ☐ Yes ☐ No

SUBSTANCE USE HISTORY

☐ **No substance use past or present** (Please skip ahead to the **General Health History** section)

☐ **No substance use past or present except tobacco products** (Please complete the **Tobacco Products** section below)

❖ **Tobacco Products**: ☐ None ☐ Yes ☐ Current ☐ Past

Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew

Daily Quantity # _____ **For how many years #** _____

❖ **Alcohol**: ☐ None ☐ Yes ☐ Current ☐ Past

If YES: ☐ Beer ☐ Wine ☐ Liquor ☐ Other (Specify: _____)

Daily Quantity # _____ **How many times per week?** _____ **For how long?** _____

Any signs of withdrawal? ☐ Yes ☐ No **Any signs of tolerance?** ☐ Yes ☐ No

Have you ever experienced: ☐ Blackouts ☐ Seizures ☐ "The Shakes": (delirium tremors)

Days sober in past month: _____ **Months sober in past year:** _____ **Longest sobriety:** _____

Health History Questionnaire

- **Cannabis**: ☐ None ☐ Yes ☐ Current ☐ Past Daily Quantity # _____

  How many times per week? _____ For how long? _____ Time of last use: _____

  Days sober in past month: _____ Months sober in past year: _____ Longest sobriety: _____

- **Cocaine**: ☐ None ☐ Yes ☐ Current ☐ Past Daily Quantity # _____

  How many times per week? _____ For how long? _____ Time of last use: _____

  Days sober in past month: _____ Months sober in past year: _____ Longest sobriety: _____

  Any signs of withdrawal? ☐ Yes ☐ No **Any signs of tolerance?** ☐ Yes ☐ No

  Days sober in past month: _____ Months sober in past year: _____ Longest sobriety: _____

- **Stimulants**: ☐ None ☐ Yes ☐ Current ☐ Past **Daily Quantity # _____**

  If YES, what kind (crystal, meth, Ritalin, etc.**)? _____**

  How many times per week? _____ For how long? _____ Time of last use: _____

  Any signs of withdrawal? ☐ Yes ☐ No **Any signs of tolerance?** ☐ Yes ☐ No

  Days sober in past month: _____ Months sober in past year: _____ Longest sobriety: _____

- **Opiates**: ☐ None ☐ Yes ☐ Current ☐ Past Daily Quantity # _____

  If YES, what kind (heroine, fentanyl, pain pills, etc.**)? _____**

  Daily Quantity # _____ How many times per week? _____ For how long? _____

  Time of last use: _____ Any signs of withdrawal? ☐ Yes ☐ No **Any signs of tolerance?** ☐ Yes ☐ No

  Days sober in past month: _____ Months sober in past year: _____ Longest sobriety: _____

- **Prescription Pills**: ☐ None ☐ Yes ☐ Current ☐ Past **Daily Quantity # _____**

  If YES, what kind (Valium, Xanax, Amphetamines, etc.**)? _____**

  How many times per week? _____ For how long? _____ Time of last use: _____

  Days sober in past month: _____ Months sober in past year: _____ Longest sobriety: _____

  Any signs of withdrawal? ☐ Yes ☐ No **Any signs of tolerance?** ☐ Yes ☐ No

- **Inhalants**: ☐ None ☐ Yes ☐ Current ☐ Past **Daily Quantity # _____**

  If YES, what kind (glues, nail polish remover, lighter fluid, spray paints, deodorant and hair sprays, whipped cream canisters, and cleaning fluids, etc.**): _____**

  How many times per week? _____ For how long? _____ Time of last use: _____

  Days sober in past month: _____ Months sober in past year: _____ Longest sobriety: _____

Health History Questionnaire

❖ **Hallucinogens**: ☐ None ☐ Yes ☐ Current ☐ Past **Daily Quantity #** _____

If YES, what kind (LSD, Mescaline/Peyote, Psilocybin, DMT, MDMA, PCP, Ketamine, etc.**):**
_____

How many times per week? _____ **For how long?** _____ **Time of last use:** _____

Days sober in past month: _____ **Months sober in past year:** _____ **Longest sobriety:** _____

❖ **Ecstasy**: ☐ None ☐ Yes ☐ Current ☐ Past **Daily Quantity #** _____

How many times per week? _____ **For how long?** _____ **Time of last use:** _____

Days sober in past month: _____ **Months sober in past year:** _____ **Longest sobriety:** _____

❖ **Other**: ☐ None ☐ Yes ☐ Current ☐ Past **Daily Quantity #** _____

If YES, name the substance(s): _____

How many times per week? _____ **For how long?** _____ **Time of last use:** _____

Days sober in past month: _____ **Months sober in past year:** _____ **Longest sobriety:** _____

❖ **Have you ever shared needles?** ☐ No ☐ Yes ☐ Current ☐ Past

❖ **Consequences of Substance use:**

☐ **Social Impairment** ☐ **Occupational Impairment** ☐ **Legal Problems** ☐ **Medical Problems**

Describe: _____

_____

- **Have you ever attempted to quit on your own? ☐ No ☐ Yes ☐ Current ☐ Past**
  If YES, please provide details: _____
  _____
  _____

- **Have you received Outpatient substance use treatment? ☐ No ☐ Yes ☐ Current ☐ Past**
  If YES, please provide details: _____
  _____
  _____

- **Have you received Inpatient substance use treatment? ☐ No ☐ Yes ☐ Current ☐ Past**
  If YES, please provide details: _____
  _____
  _____

Health History Questionnaire

- **Have you ever attended AA or other self-help groups? ☐ No ☐ Yes ☐ Current ☐ Past**
  If YES, please provide details: _____
  _____
  _____

GENERAL HEALTH HISTORY

❖ **Please check the appropriate boxes to indicate whether or not you or an immediate family member (parent, grandparents, siblings, or children) have a history of any of the following conditions:**

	SELF			Family	
Diabetes	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
High Cholesterol	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Thyroid Condition	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES: ☐ Overactive ☐ Underactive					
Hypertension/High Blood Pressure	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Heart Attack	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Headaches	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES: ☐ Migraine ☐ Tension ☐ Cluster ☐ Other: _____					
Sinus Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Nose/Throat Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Stroke	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Seizure Disorder	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Head Trauma	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Confusion	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Memory Loss	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
HIV	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown

Health History Questionnaire

	SELF			Family	
Hepatitis	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, what kind: ☐ A ☐ B ☐ C					
STD	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, what kind: _____					
Cancer	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Fibromyalgia	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Chronic Fatigue Syndrome	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Lupus	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Respiratory (Breathing) Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Heart Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Circulation Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Dermatological (Skin)/Hair Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Orthopedic/Bone & Joint Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Muscle/Movement Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Endocrine (Gland) Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					

Health History Questionnaire

	SELF			Family	
Stomach/Digestion Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Bowel Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Liver Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Kidney Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Bladder Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
Brain or Neurological Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Reproductive Organ Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Vision Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Hearing Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					
Dental/Oral Health Problems	☐ No ☐ Yes	☐ Current	☐ Past	☐ No ☐ Yes	☐ Unknown
If YES, explain: _____					

❖ **Are you currently under the care of a primary care physician?** ☐ Yes ☐ No

If YES, please provide the physician's name, address and phone number: ___

_____

_____

Last Physical Exam: _____ Results: _____

_____

Health History Questionnaire

- **Have you ever had any surgeries:** ☐ Yes ☐ No

  If YES, please complete the following table:

Surgery	Date	Reason	Outcome

- **<u>Female Patients</u>:**

  Last PAP test: _____ Result: _____ Last Period: _____

  Number of Pregnancies: ____ Number of Deliveries: _____ Number of Living Children: _____

  Number of Abortions: _____ Number of Miscarriages: _____ Number of Stillbirths: _____

- **<u>Male Patients</u>:**

  Any History of Erectile Dysfunction: ☐ No ☐ Yes ☐ Current ☐ Past

Patient Signature _____ **Date** _____

Guardian Signature _____ **Date** _____

Provider Signature _____ **Date** _____