Client Name: _____ Client ID #:_____

CLIENT HEALTH QUESTIONNAIRE

1. Have you ever had a heart attack or any problem associated with the heart? ☐ Yes ☐ No
   If ***yes***, please list when, what was the diagnosis and if you are currently taking medication:

2. Are you currently experiencing chest pain(s)? ☐ Yes ☐ No
   If ***yes***, please give details:

3. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? ☐ Yes ☐ No
   If ***yes***, please give details:

4. Have you ever been treated for HIV or AIDS? ☐ Yes ☐ No If ***yes,*** when? Please give details:

5. Have you ever been tested for sexually transmitted diseases? ☐ Yes ☐ No If ***yes***, please give details and list any medications you are taking:

6. Have you had a head injury in the last 6 months? Have you ever had a head injury that resulted in a period of loss of consciousness? ☐ Yes ☐ No
   If ***yes***, please give details:

7. Have you ever been diagnosed with diabetes? ☐ Yes ☐ No
   If ***yes***, please give details, including insulin, oral medications, or special diet:

8. Do you have any open lesions/wounds? ☐ Yes ☐ No
   If ***yes***, please explain and list any medications you are taking:

9. Have you ever had any form of seizures, delirium tremens or convulsions? ☐ Yes ☐ No
   If ***yes***, date of last seizure episode(s) and list any medications you are taking:

10. Do you use a C-PAP machine or dependent upon oxygen? ☐ Yes ☐ No
    If ***yes***, please explain:

11. Have you ever had a stroke? ☐ Yes ☐ No
    If ***yes***, please give details:

12. Are you pregnant? ☐ Yes ☐ No
    a. If yes, which trimester: ☐ 1st ☐ 2nd ☐ 3rd
       Are you receiving pre-natal care? ☐ Yes ☐ No
       Any complications? ☐ Yes ☐ No If yes, please explain:

13. Do you have a history of any other illness that may require frequent medical attention? ☐ Yes ☐ No
    If ***yes***, please give details and list any medications you are taking:

14. Have you ever had blood clots in the legs or elsewhere that required medical attention? ☐ Yes ☐ No
    If ***yes***, please give details:

15. Have you ever had high-blood pressure or hypertension? ☐ Yes ☐ No
    If ***yes***, please give details:

16. Do you have a history of cancer? ☐ Yes ☐ No
    If ***yes***, please give details and list any medications you are taking:

17. Do you have any allergies to medication, foods, animals, chemicals, or any other substance? ☐ Yes ☐ No
    If ***yes***, please give details and list any medications you are taking:

18. Have you had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? ☐ Yes ☐ No
    If ***yes***, please give details:

19. Have you ever been diagnosed with any type of hepatitis or other liver illness? ☐ Yes ☐ No
    If ***yes***, please give details and list any medications you are taking:

20. Have you ever been told you have problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? ☐ Yes ☐ No
    If ***yes***, please give details:

21. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? ☐ Yes ☐ No
    If ***yes***, please give details:

22. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidney or bladder? ☐ Yes ☐ No
    If ***yes***, please give details:

23. Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries?
    ☐ Yes ☐ No If ***yes***, please give details, including any ongoing pain or disabilities:

24. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? ☐ Yes ☐ No
    If ***yes***, list the medication(s) and how often you take it:

25. Do you take over the counter digestive medications such as Tums or Maalox? ☐ Yes ☐ No
    If ***yes***, list the medication(s) and how often you take it:

    _____

    _____

26. Do you wear glasses, contact lenses, or hearing aids? ☐ Yes ☐ No
    Or do you ***need*** glasses, contact lenses, or hearing aids? ☐ Yes ☐ No
    If ***yes*** to either, please give details:

    _____

    _____

27. When was your last dental exam? Date: _____

28. Are you in need of dental care? ☐ Yes ☐ No
    If ***yes***, please give details:

    _____

    _____

29. Do you wear or need to wear dentures or other dental appliances that may require dental care? ☐ Yes ☐ No
    If ***yes***, please give details:

    _____

    _____

30. Please describe any surgeries or hospitalizations due to illness or injury that you have had in the past:

    _____

    _____

31. When was the last time you saw a physician and/or psychiatrist? What was the purpose of the visit?

    _____

    _____

32. Over the last 2 weeks, have you had thoughts of suicide or thought you would be better off dead? ☐ Yes ☐ No
    If ***yes***, describe:

    _____

    _____

33. Have you attempted suicide in the past two (2) years? ☐ Yes ☐ No If ***yes***, give dates:

    _____

    _____

34. Have you ever harmed yourself/others or thought about harming yourself/others? ☐ Yes ☐ No If ***yes,*** describe:

    _____

    _____

35. Have you ever been in a relationship where your partner has pushed or slapped you? ☐ Yes ☐ No
    If ***yes***, describe:

    _____

    _____

36. Additional Comments:

    _____

    _____

    _____

    _____

    _____

    _____

I declare that the above information is true and correct to the best of my knowledge:			
Client Signature		**Date**	
Reviewing Facility/Program Staff Name			
Reviewing Facility/Program Staff Signature		**Date**	