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