Deborah Chavez, Ph.D., MFT

HEALTH QUESTIONAIRE

CHILD
Name____Date_________________________

Please check all conditions you have had or currently have:

	Lung/Respiratory/Breathing problems
	Headache problems
	Liver problems
	Kidney problems
	Diabetes
	Arthritis or Rheumatism
	Heart problems
	Circulation problems
	High Blood Pressure/Stroke
	Epilepsy/Convulsions/Seizures
	Thyroid Disorder
	Digestion problems
	Bowel problems
	Bladder problems
	Anemia/Blood Diseases
	Cancer
	Sexually transmitted diseases, HIV, AIDS
	Skin problems
	Hearing problems
	Visual problems
	Taste/smell/swallowing problems
	Any other serious illnesses or injuries which required treatment

Check all boxes that apply to you:

	Past 30 days	Ever in my life
Serious Depression		
Anxiety or Tension		
Hallucinations		
Trouble understanding, concentrating/remembering		
Trouble controlling violence		
Thoughts of suicide		
Attempted to kill self		
Thoughts of hurting someone		
Been prescribed medication for any emotional problem		
Felt out of contact with myself		
Lost track of time		
Had a blackout		
Felt my thoughts or actions were controlled by others		
Had problems with alcohol and/or drugs		

Women Only

	Number of times pregnant
	Currently pregnant
	Number of miscarriages or abortions
	Menopause
	Severe pain/cramps during periods
	Severe mood change during periods

Have you been treated for emotional problems in the past? Yes____No____

Have you ever been treated for drug or alcohol problems? Yes____No____

Please list all medications your currently take, medical problem being treated, dosage, and prescribing physician

Medical Condition Name of Medication Dosage/Day Prescribing Physician