PHYSICAL HEALTH QUESTIONNAIRE

Client Name: _____ ID Number: _____

Are you being treated for, or have you ever had any of the following problems? If yes, please explain the nature of the problem, dates and treatment in the space provided.

YES NO

____ _____ Problems with eyes, ears, nose or throat? _____

_____

____ _____ Glaucoma? _____

____ _____ Dizziness, fainting, headache, fatigue, seizures or head injuries? _____

_____

____ _____ Chest pains, high blood pressure, heart attack, stroke or other heart disorders, blood disorders, hardening of the arteries?

____ _____ Cough, shortness of breath, asthma, chronic obstructive pulmonary disease or other respiratory disease? _____

_____

____ _____ Ulcers or other stomach or bowel symptoms? _____

____ _____ Diabetes, thyroid, pancreas, liver or jaundice problems? _____

_____

____ _____ Disorder of muscles, bones, back or joint arthritis? _____

_____

____ _____ Any allergies (plants, animals, food, etc?) _____

_____

_____ _____ Disorders of the skin, tumor or cancer, severe infections? _____

_____

_____ _____ Problems with female or male organs? _____

_____

_____ _____ Venereal (sexually transmitted) diseases? _____

_____ _____ Menopausal? _____ _____ Are you Pregnant? _____

_____ _____ Any problems with pregnancy? _____

_____ _____ Infectious Disease (Tuberculosis, hepatitis, AIDS, etc? _____

_____

_____ _____ Quantity and Frequency of Alcohol/non-prescription drugs/street drugs

_____

_____

_____ _____ DT's or Blackouts? _____

_____ _____ Do you smoke tobacco? How many packs per day? _____

_____ _____ Major health problems, hospitalizations, surgeries, ER visits (not listed above? _____

_____

_____

_____ _____ Have you ever been under a doctor's care? If yes, for what reason? _____

_____

_____ _____ Have members of your family had a history of alcohol or drug abuse, depression, major Mental/emotional problems, or other major illnesses? Please list who and what: _____

_____

_____ _____ Are you sleeping well? _____

_____ _____ Do you use alcohol/drugs/medications to help you sleep? _____

Last Physical Examination: _____ Name of Physician: _____

Doctor or clinic's address/phone: _____

Dentist's name and date of last examination: _____

Do you have any condition that my effect your participation in this program: _____

NUTRITIONAL

_____ _____ Are you required to be on a special diet? If so, describe: _____

_____

_____ _____ Have you had a change in appetite or weight in the last six months; if so, how much?

_____ _____ Do you diet? _____

_____ _____ Do you use diet pills? _____

_____ _____ Have you gone more than a day without eating any food, except when ill? _____

MEDICATION PROFILE

List all over-the-counter medications, herbal remedies and all prescribed medications you are currently taking.

Medicine	Dosage	How Often	How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medication or ever had a reaction to any medication? If yes, what was the medication and what was the reaction? _____

_____

Preparer's Signature: _____ Date: _____

SUMMARY OF CLIENT'S NEEDS

Does the clinician believe that this client has a medical condition that will interfere with participation in this program?_____

_____

Is there a need to refer this client for a medical consultation? _____

_____

If so, what action was taken? _____ Referral to Family Physician _____Other _____Refusal

Clinician's Signature: _____ Date: _____