Worthington Consultation & Behavioral Medicine
134 North Woods Blvd. Suite B1
Columbus, OH 43235
Office (614) 846-6611 / Fax: 846-6662

Rev. 11/14/08

HEALTH QUESTIONNAIRE

NAME:		Date:
DOB:		Age:
Weight:		

REASON FOR THE VISIT	Please list your problems and/or symptoms:
1	
2	
3	

CURRENT MEDICATIONS (and Doses):			
1		2	
3		4	
5		6	
7		8	
9		10	
MEDICATION ALLERGIES:			
1		2	
3		4	

PAST PSYCHIATRIC HISTORY: (Check all that apply)			
☐	Anxiety / Nervousness	☐	Paranoid feelings
☐	Depression	☐	Obsessive thoughts
☐	Mood Swings	☐	Obsessive habits
☐	Insomnia / Oversleeping	☐	Low energy
☐	Problems concentrating	☐	Hopeless feelings
☐	Hearing voices or sounds	☐	Thoughts about death
☐	Seeing visions	☐	Suicide thoughts

PAST HOSPITALIZATIONS:	
Year:	Reason for hospital admission:

FAMILY HISTORY: (Check all that apply)			
☐	Anxiety / Nervousness	☐	Alcoholism
☐	Depression	☐	Drug Addiction
☐	Mood Swings (Bipolar)	☐	Attention Deficit & Hyperactivity
☐	Schizophrenia	☐	Obsessive Compulsive Disorder

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DRUG & ALCOHOL HISTORY			
USE?	Yes or No	Amount used per day or per week	Last time used
CIGARETTES			
ALCOHOL			
OPIATES			
COCAINE			
MARIJUANA			
SPEED			
SEDATIVES			
Other drug used:			
Other drug used:			

CURRENT WITHDRAWAL SYMPTOMS: (Check all that apply)			
☐	Nose or eyes running	☐	Nausea
☐	Sneezing	☐	Vomiting
☐	Sweating	☐	Diarrhea
☐	Chills & hot flashes	☐	Problems sleeping
☐	Anxiety	☐	Headache
☐	Tremors	☐	Hallucinations
☐	Muscle & joint aches	☐	Other:

CURRENT MEDICAL PROBLEMS:			
1		2	
3		4	
5		6	
7		8	
9		10	

FOR WOMEN ONLY:	
Date of last Menstrual Period	
Use of Birth Control	
Type of Birth Control	