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 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:
   ____
   ____

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

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

7. 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:
   ____
   ____

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

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

   ____
   ____

10. 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:

    ____
    ____

11. 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:

    ____
    ____

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

    ____
    ____

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

    ____
    ____

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

    ____
    ____

15. 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:

    ____
    ____

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

    ____
    ____

17. 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:

    ____

    ____

18. 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:

    ____

    ____

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

    ____

    ____

20. 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:

    ____

    ____

21. 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:

    ____

    ____

22. 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:

    ____

    ____

23. 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:

    ____

    ____

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

    ____

    ____

25. When was your last dental exam? Date: ______________________

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

    ____

    ____

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

    ____

    ____

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

    ____

    ____

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

    ____

    ____

30. Additional Comments:

    ____

    ____

I declare that the above information is true and correct to the best of my knowledge:

Client Signature: ____________________________ Today's Date: ____________________

Reviewing Facility/Program Staff Name: ______________________________________

Reviewing Facility/Program Staff Signature: ________________________ Date: ______________