

Visions Counseling Inc.

Wendi Martell-Daniels, LCSW, SAC

History Questionnaire

Patient's Name: (Last) _____ (First) _____ (M.I.) _____

Patient's Birth Date: ____/____/____ Age: _____ Sex: M F

Patient's Education Level: PK K 1 2 3 4 5 6 7 8 9 10 11 12 12+ BS MA PHD

Patient's School or Employer: _____

Patient's Occupation: _____

Patient's Favorite Hobby/Activity: _____

Who is completing this form? _____

What is your relationship to the patient? _____

Address: _____

Home Telephone: (____) _____ - _____

Cell Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Fax: (____) _____ - _____

E-Mail Address: _____

How did you hear about Visions Counseling, Inc.? _____

What is your goal in coming here? How can we be most useful to you? _____

Who lives in the same house/apartment with the patient?

Name	Relationship to Patient	Age	Occupation/Grade In School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What family members are significantly involved in the patient's life but do not live with the patient?

Name	Relationship to Patient	Age	Occupation/Grade In School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there a family history of mental health or drug and alcohol problems? Yes No Please explain (who and what): _____

Is there a family history of suicide or homicide? Yes No Please explain: _____

Has the patient ever attempted suicide? Yes No Please explain (When and How): _____

Has the patient ever been hospitalized for mental health or drug and alcohol problems? Yes No
Please Explain (When, Where, and Why): _____

Has the patient ever been in therapy before? Yes No Please Explain (When, With Whom, and Why): _____

Patient's Height: _____ Patient's Weight: _____

Primary Care Physician: _____

Office Location: _____

Phone Number: (____) _____ - _____

What medical problems, if any, is the patient currently having? _____

What medications are the patient currently taking?

Medication	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date of last physical exam: ____ / ____ / ____

Reason for exam: _____

Allergies: _____

Hospitalizations for Operations, Injury, or Serious Illness (When, Where, and Why): _____

Does the patient:

Smoke? Yes No How much/often? _____

Chew Tobacco? Yes No How much/often? _____

Drink Caffeine? Yes No How much/often? _____

Drink Alcohol? Yes No Which Kinds? Beer Wine Hard Liquor

How much? 0-2 Drinks 3-5 Drinks 6-9 Drinks 10+ Drinks

How often? Daily 3-5 Times/Week 1-2 Times/Week 1-2 Times/Month

Use Drugs? Yes No Which Kinds? _____

How much/often? _____

Do you sometimes drink more alcohol or use more drugs than planned? Yes No

Have family or friends ever been concerned about your alcohol or drug use? Yes No

Have you ever been arrested (including OWIs) for alcohol or drug related offenses? Yes No

Have you ever been treated for alcohol or drug use/abuse/dependence? Yes No

Have you ever overdosed? Yes No

Have you ever had blackouts (loss of memory)? Yes No

Please check any of the following diseases the patient has had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Kidney Disorder |
| <input type="checkbox"/> Strep Infection | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke | |

Please check any of the following complaints the patient is currently experiencing:

- | | | |
|---|--|---|
| <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Palpitation of Heart | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficult or Painful Urination |
| <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Sexual Difficulties | <input type="checkbox"/> Swelling in Ankles and Legs |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Easy Bleeding or Bruising |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Blood with Cough | <input type="checkbox"/> Other Heart Trouble | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Abnormal Chest X-ray | <input type="checkbox"/> 10+ Pound Weight Gain or Loss | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Recurrent Abdominal Pain | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Pain in Chest | <input type="checkbox"/> Tarry/Black Stools | <input type="checkbox"/> Homicidal Thoughts |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Frequent Nausea or Vomiting | |
| <input type="checkbox"/> Numbness/Tingling in hands or feet | <input type="checkbox"/> Changes in Bowel Habits | |

Women Only:

- ☐ Vaginal Bleeding or Discharge (Not part of period)
- ☐ Enlarged Glands (lumps) in neck, armpit, or groin
- ☐ Pregnant

Men Only:

- ☐ Genital Pain, Sores, or Infection
- ☐ Enlarged Glands (lumps) in neck, armpit, or groin