PART A: CASA COMMUNITY SERVICES BEHAVIORAL HEALTH SERVICES MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____ Client ID# _____

1. Are you currently taking any **medications** (prescription, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)? ☐ No, go to question 2.
☐ Yes, answer questions 1(a) - 1(e) below.

1(a) Identify the medications that you are currently taking for medical or behavioral health concerns and the reason for taking the medications below:

Name of Medication	Reason for Taking Medication
Name of Medication	Reason for Taking Medication
Name of Medication	Reason for Taking Medication
Name of Medication	Reason for Taking Medication
Name of Medication	Reason for Taking Medication
Name of Medication	Reason for Taking Medication
Name of Medication	Reason for Taking Medication

1(b) Have any of your medications been changed in the last month? ☐ No ☐ Yes**,** list the medications that have changed and explain why they were changed. _____

1(c) How long will your current supply of medications last? (How urgent is your need to obtain medications?) _____

1(d) Describe any side effects that you find troublesome from any of the medications you are currently taking. _____

1(e) Do you have any abnormal/unusual muscle movements? ☐ No ☐ Yes, how is it being treated? _____

2. Are you **allergic** to any medications? ☐ No ☐ Yes, which ones? _____

3. Do you have any other **allergies**? ☐ No ☐ Yes, describe them. _____

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4. When was the last time you saw your **primary care physician/dentist** and what was the purpose of that visit? 1) PCP:_____

2)Dentist:_____

5. Do you have any history of **head injury** with concussion or loss of consciousness? ☐ No ☐ Yes, describe._____

6. Are you currently **pregnant**? ☐ No ☐ Yes ☐ Unsure

7. Are there any **medical problems** that you are currently receiving treatment for? ☐ No, go to question 8. ☐ Yes, answer 7(a) and 7(b) below.

7(a) Describe below what current medical problems you have and what type of treatment you are currently receiving.

Medical Problem	Type of Treatment Receiving

7(b) Does your current medical condition(s) create problems in how you deal with life, including pain? ☐ No ☐ Yes, if yes explain._____

8. Have you recently experienced any of the following?

Ear/Nose/Throat:			
Severe dry mouth	☐ No	☐ Yes, when	_____
Ear infections	☐ No	☐ Yes, when	_____
Persistent sore throat	☐ No	☐ Yes, when	_____
Respiratory System:			
Respiratory infections	☐ No	☐ Yes, when	_____
Persistent cough	☐ No	☐ Yes, when	_____
Shortness of breath	☐ No	☐ Yes, when	_____
Cardiovascular:			
Chest pain	☐ No	☐ Yes, when	_____
Swelling in legs, ankles, feet	☐ No	☐ Yes, when	_____
Gastro-intestinal:			
Persistent nausea / vomiting	☐ No	☐ Yes, when	_____
Self-induced vomiting	☐ No	☐ Yes, when	_____
Frequent or prolonged diarrhea / constipation	☐ No	☐ Yes, when	_____
Excessive use of laxatives	☐ No	☐ Yes, when	_____
Weight loss / gain	☐ No	☐ Yes, when	_____
Blood in stools	☐ No	☐ Yes, when	_____
Abdominal pain	☐ No	☐ Yes, when	_____

Genitourinary:

Urinary discomfort	☐ No	☐ Yes, when	_____
Frequent urination	☐ No	☐ Yes, when	_____
Blood in urine	☐ No	☐ Yes, when	_____

Musculoskeletal:

Joint pain	☐ No	☐ Yes, when	_____
Back pain	☐ No	☐ Yes, when	_____

Neurological:

Facial or muscle twitching/jerking	☐ No	☐ Yes, when	_____
Seizures	☐ No	☐ Yes, when	_____
Passing out	☐ No	☐ Yes, when	_____
Dizziness	☐ No	☐ Yes, when	_____
Headaches	☐ No	☐ Yes, when	_____

Infectious Diseases:

Sexually Transmitted Diseases	☐ No	☐ Yes, when	_____

Other:

Inappropriate defecation (bowel elimination)	☐ No	☐ Yes, when	_____
Inappropriate bed wetting	☐ No	☐ Yes, when	_____
Dry skin	☐ No	☐ Yes, when	_____
Hair loss	☐ No	☐ Yes, when	_____
Unusual sweats or chills	☐ No	☐ Yes, when	_____
Surgeries	☐ No	☐ Yes, when	_____
Problem with sleeping	☐ No	☐ Yes, when	_____

Other conditions not listed above (signs and symptoms)

_____

_____

_____

_____

9. Do you **use tobacco**? ☐ No ☐ Yes, how much per day? _____ How long have you been using tobacco? _____ (yrs/mths)

10. Do you consume **caffeine**? ☐ No ☐ Yes, how many cups/cans do you drink per day? _____

11. In total, how much **fluid** do you drink, i.e., how many cups/cans of total fluids do you drink per day? _____

12. Have you **ever received out-patient** (office OR home-based) **behavioral health (counseling/therapy) services**, been **hospitalized** or received services in a **residential facility** for **behavioral health concerns**? ☐ No, go to question 13.
☐ Yes, answer questions 12(a) – 12(c).

12(a) Describe below the type of treatment you received to address your behavioral health concerns and when you received this treatment.

Type of Treatment	When and Where Received
Type of Treatment	When and Where Received
Type of Treatment	When and Where Received

12(b) What current or prior treatment/services, including medication, do you think have been the most helpful in addressing your behavioral health symptoms? Explain

12(c) What current or prior treatment/services, including medication, do you think have been the least helpful in addressing your behavioral health symptoms? Explain

13. Describe any current or past **behavioral health issues** (including substance abuse) in your **family.** (*For purposes of this question family may include birth family, adopted family, foster family and/or family person is or has lived with.*)

Client Name (please print) _____ Date _____ Phone _____

If you were provided assistance in filling out this questionnaire, please provide the name, date of completion and telephone number of the individual providing this assistance.

Name (please print) _____ Date _____ Phone _____