Catholic Community Services in Western Arizona
Health Questionnaire

Instructions: Please answer the following questions to the best of your ability. This will help us understand your current/past health history.

Medications

Are you currently taking any **medications** (prescription, over the counter vitamins, homeopathic or naturopathic remedies, traditional or alternative medicine remedies, herbs)?

☐ No.

☐ Yes, answer question below.

Provide the names and dosage of medications currently taking:

Name of Medication	Reason for Taking Medication

☐ More listed no back.

Medical

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

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

3. Do you have any history of **serious injuries/accidents or surgeries**?
☐ No ☐ Yes, describe.

4. Are you currently **pregnant**? ☐ No ☐ Yes ☐ Unsure ☐ N/A

5. Do you **use tobacco**? ☐ No ☐ Yes, amount per day: _____
How long have you been using tobacco? _____ (yrs/months)

6. Do you consume **caffeine**? ☐ No ☐ Yes, amount per day: _____ (cups)

Client Name: _____ Client ID: _____

7. Have you recently experienced any of the following?

Unusual sweats or chills ☐ No ☐ Yes, when _____

Passing out ☐ No ☐ Yes, when _____

Persistent nausea / vomiting ☐ No ☐ Yes, when _____

Self-induced vomiting ☐ No ☐ Yes, when _____

Ear infections ☐ No ☐ Yes, when _____

Persistent sore throat ☐ No ☐ Yes, when _____

Excessive use of laxatives ☐ No ☐ Yes, when _____

Inappropriate defecation (bowel elimination) ☐ No ☐ Yes, when _____

Facial or muscle twitching/jerking ☐ No ☐ Yes, when _____

Dry skin ☐ No ☐ Yes, when _____

Hair loss ☐ No ☐ Yes, when _____

Sexually Transmitted Diseases ☐ No ☐ Yes, when _____

specify: _____

Pain: Recurring continual pain/physical discomfort anywhere (e.g., headaches, joint/back pain, chest/abdominal pain) ☐ No ☐ Yes, specify: _____

_____

Other conditions not listed above (signs and symptoms)

_____

History of Treatment

1. Have you **ever received out-patient** (office-based) **services**, been **hospitalized** or received services in a **residential facility** for **behavioral health concerns**?

☐ No.

☐ Yes, answer questions 2(a) – 2(c).

2(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
_____	_____
_____	_____
_____	_____
_____	_____

Completed by: _____ Date: _____

Client Name: _____ Client ID: _____