Hallowell Center, P.C

144 North Rd Suite 2450
Sudbury Ma 01776
978-287-0810

Health History Questionnaire

Name: _____ Today's Date: _____

Birth Date: _____

What is your reason for coming to see us? _____

_____

Primary Care Physician: _____ Telephone: _____

Symptoms: Check all symptoms you currently have or have had this year

___ anger
___ anxiety
___ addictions
___ aggressive behavior
___ attention problems
___ career problems
___ compulsive behavior
___ depression
___ disorganization
___ eating problems
___ fears and phobias
___ flashbacks
___ gambling problems
___ headache
___ impulsive behavior
___ irritability
___ learning problems
___ marital problems
___ moodiness
___ negativity
___ obsessive thinking
___ procrastination
___ perfectionism
___ premenstrual problems
___ panic
___ parenting problems
___ relationship problems
___ stress
___ sexual problems
___ seasonal mood changes
___ worry

Physical Symptoms: Check all symptoms you currently have or have had this year

___ asthma
___ bleeding
___ breathing problems
___ bruising
___ chest pains
___ constipation
___ diarrhea
___ dizziness
___ fevers
___ hearing problems
___ high blood pressure
___ involuntary movements
___ irregular heart beat
___ joint pain
___ muscle pain
___ numbness
___ passing out
___ seizures
___ stomach pains
___ visual changes
___ weakness

Conditions: Please list all conditions you have had

_____

_____

_____

Medications: Please list all prescriptions and non-prescription medications that you take

1. _____ 2._____ 3. _____

4. _____ 5. _____ 6. _____

Marital Status : ___ single ___ married ___ divorced ___ widowed

Children	**Age**	**Health Status**	**School Status**
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Occupation: _____

Primary Sources of Stress in Occupation, if any; _____

_____

Health Habits:

Do you exercise? _____ yes _____ no What type of exercise? _____

Do you get regular check ups? _____ yes _____ no

Do you use alcohol? _____ tobacco? _____ drugs? _____

caffeine? _____

Family History: Please check any condition present in a blood relative

___ alcoholism ___ abuse ___ anxiety ___ attention deficit disorder

___ bipolar disorder ___ depression ___ psychosis ___ suicide

___ trauma ___ violence ___ obsessive compulsive disorder

Family Health Status:

	Age	**state of health**	**quality of relationship**
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____

Treatment History:

Hospitalizations: _____

Prior psychotherapy: _____

Prior psychiatric care: _____

Serious illness or injury: _____

Medical Conditions: _____

Surgeries: _____

I certify that the above information is correct to the best of my knowledge and that I have not purposefully misrepresented my health history. I will not hold my doctors or any members of his staff responsible for errors or omissions that I may have made in completing this form.

_____ _____

Signature **Date**

_____ _____

Reviewed by **Date**