SAN BERNARDINO COUNTY | Behavioral Health

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RESET

# CLIENT HEALTH QUESTIONNAIRE AND INITIAL SCREENING QUESTIONS

## CLIENT HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____

Date: _____

## Physical

| | Yes | No | |
|---|---|---|---|
| 1. | ☐ | ☐ | Have you ever had a heart attack or any problem associated with the heart? If ***yes***, please list when, what was the diagnosis and if you are currently taking medication: |

_____
_____
_____
_____

| | | | |
|---|---|---|---|
| 2. | ☐ | ☐ | Are you currently experiencing chest pain(s)? 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? If ***yes***, please give details: |

_____
_____
_____
_____

| | Yes | No | |
|---|---|---|---|
| 4. | ☐ | ☐ | Have you ever tested positive for tuberculosis? If ***yes***, when? Please give details: |
| 5. | ☐ | ☐ | Have you ever been treated for HIV or AIDS? If ***yes***, when? Please give details: |
| 6. | ☐ | ☐ | Have you ever been tested for sexually transmitted diseases? If ***yes***, please give details and list any medications you are taking: |
| 7. | ☐ | ☐ | Have you had a head injury in the last six (6) months? Have you ever had a head injury that resulted in a period of loss of consciousness? If ***yes***, please give details: |
| 8. | ☐ | ☐ | Have you ever been diagnosed with diabetes? If ***yes***, please give details, including insulin, oral medications, or special diet: |
| 9. | ☐ | ☐ | Do you have any open lesions/wounds? If ***yes***, please explain and list any medications you are taking: |

| | Yes | No | |
|---|---|---|---|
| 10. | ☐ | ☐ | Have you ever had any form of seizures, delirium tremens or convulsions? If ***yes***, date of last seizure episode(s) and list any medications you are taking: |

11. ☐ ☐ Do you use a C-PAP machine or dependent upon oxygen? If ***yes***, please explain:

12. ☐ ☐ Have you ever had a stroke? If ***yes***, please give details:

13. ☐ ☐ Are you pregnant?

a. If ***yes***, Which Trimester: ☐ 1st ☐ 2nd ☐ 3rd
Are you receiving pre-natal care? ☐ Yes ☐ No
Any complications? ☐ Yes ☐ No If **yes**, please explain:

14. ☐ ☐ Do you have a history of any other illness that may require frequent medical attention? If ***yes***, please give details and list any medications you are taking:

| | Yes | No | |
|---|---|---|---|
| 15. | ☐ | ☐ | Have you ever had blood clots in the legs or elsewhere that required medical attention? If ***yes***, please give details: |
| 16. | ☐ | ☐ | Have you ever had high-blood pressure or hypertension? If ***yes***, please give details: |
| 17. | ☐ | ☐ | Do you have a history of cancer? If ***yes***, please give details and list any medications you are taking: |
| 18. | ☐ | ☐ | Do you have any allergies to medications, foods, animals, chemicals, or any other substance? If ***yes***, please give details and list any medications you are taking: |
| 19. | ☐ | ☐ | Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If ***yes***, please give details: |
| 20. | ☐ | ☐ | Have you ever been diagnosed with any type of hepatitis or other liver illness? If ***yes***, please give details and list any medications you are taking: |

| | Yes | No | |
|---|---|---|---|
| 21. | ☐ | ☐ | Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If ***yes***, please give details: |
| 22. | ☐ | ☐ | Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If ***yes***, please give details: |
| 23. | ☐ | ☐ | Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder? If ***yes***, please give details: |
| 24. | ☐ | ☐ | Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If ***yes***, please give details, including any ongoing pain or disabilities: |
| 25. | ☐ | ☐ | Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If ***yes***, list the medication(s) and how often you take it: |
| 26. | ☐ | ☐ | Do you take over the counter digestive medications such as Tums or Maalox? If ***yes***, list the medication(s) and how often you take it: |

| | Yes | No | |
|---|---|---|---|
| 27. | ☐ | ☐ | Do you wear or need to wear glasses, contact lenses, or hearing aids? If ***yes***, please give details: |
| 28. | ☐ | ☐ | When was your last dental exam? Date: |
| 29. | ☐ | ☐ | Are you in need of dental care? If ***yes***, please give details: |
| 30. | ☐ | ☐ | Do you wear or need to wear dentures or other dental appliances that may require dental care? If ***yes***, please give details: |

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

32. When was the last time you saw a physician and/or psychiatrist? What was the purpose of the visit? Please give details:

33. In the past seven days what types of drugs, including alcohol, have you used?

| Type of Drug | Route of Administration |
|---|---|
| | |
| | |
| | |
| | |

34. In the past year what types of drugs, including alcohol, have you used?

| Type of Drug | Route of Administration |
|---|---|
| | |
| | |
| | |
| | |

35. Do you take any prescription medications including psychiatric medications?

| Type of Drug | Route of Administration |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Mental/Emotional

| | Yes | No | |
|---|---|---|---|
| 36. | ☐ | ☐ | Are you currently feeling down, depressed, anxious or hopeless? If ***yes,*** describe: |
| 37. | ☐ | ☐ | Are you currently receiving treatment services for an emotional/psychiatric diagnosis? If ***yes***, for what are you being treated? |
| 38. | ☐ | ☐ | Over the last 2 weeks, have you felt nervous, anxious, or on edge? Did you feel like you were unable to stop or control your worrying? If ***yes***, describe: |
| 39. | ☐ | ☐ | Over the last 2 weeks, have you had thoughts of suicide or thought that you would be better off dead? If ***yes***, describe: |
| 40. | ☐ | ☐ | Have you attempted suicide in the past two (2) years? If ***yes***, give dates: |
| 41. | ☐ | ☐ | Have you ever harmed yourself/others or thought about harming yourself/others? If ***yes***, describe: |

| | Yes | No | |
|---|---|---|---|
| 42. | ☐ | ☐ | Are you currently feeling that you're hearing voices or seeing things? If ***yes***, describe: |

43. ☐ ☐ Have you ever been in a relationship where your partner has pushed or slapped you? If ***yes***, describe:

## Previous Drug and/or Alcohol Treatment Services

44. Have you received alcoholism or drug abuse recovery treatment services in the past? If ***yes***, please give details:

| Type of Previous Recovery Treatment (Outpatient, Residential, Detoxification) | Name of Previous Treatment Facility | Dates of Previous Treatment | Treatment Completed (Yes or No) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |

45. Have you ever been treated for withdrawal symptoms? If so, please state the dates you were treated and list any medications that were prescribed:

46. The client has been informed of the risks and benefits of Medications for Addiction Treatment (MAT) also known as Medication Assisted Treatment. Additionally, the provider described the availability of MAT at the program, if applicable, or the referral process for MAT.

_____ _____
(Client Initial) (Staff Initial)

47. The client has been screened for use of all tobacco products utilizing questions recommended in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders under tobacco use disorder, or similar evidence-based guidance, for determining that an individual has a tobacco use disorder.

_____ _____
(Client Initial) (Staff Initial)

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

Client Name (printed) _____

Client Signature: _____ Date: _____

Program Staff Name (printed) _____

Program Staff Signature: _____ Date: _____

Facility Name: _____

**Additional Comments:**