CCMHS – Health History Questionnaire

Name: _____ Date: _____

Family Physician: _____ Date of Last Exam: _____

Specialist(s): _____ Date of Last Exam: _____

Specialty: _____

Specialist(s): _____ Date of Last Exam: _____

Specialty: _____

Current Medication: _____ Dosage: _____ Frequency: _____

Current Medication: _____ Dosage: _____ Frequency: _____

Current Medication: _____ Dosage: _____ Frequency: _____

Previous Mental Health Services: ☐ Yes ☐ No

_____ When: _____ ☐ Inpatient ☐ Outpatient

_____ When: _____ ☐ Inpatient ☐ Outpatient

Have you ever been told you had:

☐ Anemia	☐ Diabetes, sugar	☐ Glaucoma
☐ Sickle Cell Disease	☐ Hypoglycemia/low blood sugar	☐ Ulcers
☐ Sexually Transmitted Disease	☐ Thyroid Disease	☐ Stroke
☐ HIV/AIDS	☐ Kidney Disease	☐ Cancer/Location _____
☐ Hepatitis	☐ Asthma or Allergies	☐ Tuberculosis
☐ Heart Disease	☐ Epilepsy	☐ Bladder trouble
☐ Rheumatic fever	☐ Seizure Disorder	☐ Emphysema
☐ High Blood Pressure	☐ Arthritis or Joint Disease	☐ Alcoholism/Drug Addiction

Rate your general health as of now. ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Have you ever had surgery? ☐ Yes ☐ No

Do you feel excessively tired or weak? ☐ Yes ☐ No

Have you lost or gained weight for no apparent reason in the last six weeks? ☐ Yes ☐ No

Have you lost interest in eating recently? ☐ Yes ☐ No

Do you have problems either falling asleep or staying asleep? ☐ Yes ☐ No

Has there been any recent change in your sexual interest? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If yes, how much? _____

Do you drink six or more cups of coffee, tea, and/or pop a day? ☐ Yes ☐ No

Do you currently have or experience any of the following: (Check all that apply)

☐ Frequent headaches	☐ Chest pains	☐ Numbness
☐ Double vision	☐ Shortness of breath	☐ Fits, Convulsions, or Epilepsy
☐ Blurred vision	☐ Dizzy spells	☐ Tendency to shake/tremble
☐ Eyesight worsening	☐ Swollen feet or ankles	☐ Constipation
☐ Deafness/hearing loss	☐ Vomit blood	☐ Sweating
☐ Dental problems	☐ Rectal bleeding	☐ Dry mouth
☐ Sore tongue	☐ Stomach pain	☐ Irritability
☐ Many chest colds	☐ Frequent urination	☐ Fast pulse
☐ Sore throats	☐ Night urination	☐ Oversensitive to heat or cold
☐ Frequent coughing	☐ Difficulty starting urination	☐ Hyperactivity
☐ Wheezing, gasping	☐ Bloody or coffee colored urine	☐ Diarrhea
		☐ Lower back pain

List any drug allergies or drug sensitivities you may have: _____

_____

Summary of Findings: _____

_____

Recommendations: _____

HHQ & Proxy Health Measures Reviewed by: _____ / _____

Signature / Credential **Date**

PLEASE CONTINUE ON REVERSE SIDE

CCMHS - Simple Screening Instrument for Substance Abuse Self-Administered Form

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

During the last 6 months. . .

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants.)	☐ Yes ☐ No
2. Have you felt that you use too much alcohol or other drugs?	☐ Yes ☐ No
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?	☐ Yes ☐ No
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)	☐ Yes ☐ No
5. Have you had any health problems? For example, have you: ☐ Had blackouts or other periods of memory loss? ☐ Injured your head after drinking or using drugs? ☐ Had convulsions, delirium tremens ("DTs")? ☐ Had hepatitis or other liver problems? ☐ Felt sick, shaky, or depressed when you stopped? ☐ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs? ☐ Been injured after drinking or using? ☐ Used needles to shoot drugs?	
6. Has drinking or other drug use caused problems between you and your family or friends?	☐ Yes ☐ No
7. Has your drinking or other drug use caused problems at school or at work?	☐ Yes ☐ No
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)	☐ Yes ☐ No
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?	☐ Yes ☐ No
10. Are you needing to drink or use drugs more and more to get the effect you want?	☐ Yes ☐ No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	☐ Yes ☐ No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?	☐ Yes ☐ No
13. Do you feel bad or guilty about your drinking or drug use?	☐ Yes ☐ No

The next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem?	☐ Yes ☐ No
15. Have any of your family members ever had a drinking or drug problem?	☐ Yes ☐ No
16. Do you feel that you have a drinking or drug problem now?	☐ Yes ☐ No

Thanks for filling out this questionnaire.

Results: _____

Recommendations: _____

_____

_____