Signature Health
Physical Health Questionnaire

Name: _____ Date: _____

Do you have any medical conditions? No ___ Yes ___, if Yes, please explain:

_____

_____

Have you had any ER visits in the past year? No_____ Yes_____, if Yes, please explain:

_____

_____

Have you ever been hospitalized? No____ Yes____, if Yes, please explain:

_____

_____

Do you have any physical disabilities? No _____ Yes _____, if Yes, please explain:

_____

_____

Do you have any developmental disabilities? No _____ Yes _____, if Yes, please explain:

_____

_____

Do you have any allergies? No_____ Yes_____, if yes, please list:_____

Do you have a primary care doctor? No_____ Yes_____, If yes, who: _____

FOR CHILD AND ADOLESCENT ASSESSMENT ONLY:

Are childhood immunizations current? Yes____ No____

Mother's health during pregnancy: ____ Healthy, Problems: _____

_____

Mother Used: Tobacco_____ Alcohol_____ Drugs_____ during pregnancy? Yes____ No____

Birth complications? No ____ Yes ____, if Yes, please explain: _____

_____

Did your child's early development seem normal to you? Yes ___ No ____, if No, please explain:

Signature Health
Physical Health Questionnaire

Medications (include over the counter medications):

Name of Medication	Dose Mgs	How often it's taken	Prescribed by who, for what	How long have you been taking it?	Any recent changes in dosage, frequency, etc.?

Current troublesome side effects? No_____ Yes_____, if Yes, please explain: _____

_____

Any past problems with any medication? No_____, Yes_____, if Yes, please explain:_____

_____

Do you have a sufficient supply of medications? Yes_____ No_____, if No, please explain:_____

Do you think you medications help you? Yes_____ No_____, if No, please explain: _____

Have you had difficulty remembering to take your medications? Yes_____ No_____

Are you willing to consider use of medications to help with your mental health problems? Yes_____ No_____