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# Confidential Health History Questionnaire

Today’s Date\_\_\_\_\_\_\_\_\_\_\_ Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to contact? Y or N Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to contact? Y or N

1. What goals do you have for us working together?

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2. When did the difficulty begin and what motivated you to seek this appointment at this time?

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3. What help have you sought for this problem or related problems? Include dates of past therapy.

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4. What results did you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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5. List all current medications or treatments for health problems, including natural remedies and vitamins, use back if necessary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. If you are taking medications, list the prescribing physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you use:

Alcohol \_\_\_Yes \_\_\_No Frequency of Use\_\_\_\_\_\_ Amount\_\_\_\_\_\_

Drugs \_\_\_Yes \_\_\_No Frequency of Use\_\_\_\_\_\_ Amount\_\_\_\_\_\_

Tobacco \_\_\_Yes \_\_\_No Frequency of Use\_\_\_\_\_\_ Amount\_\_\_\_\_\_

Caffeine \_\_\_Yes \_\_\_No Frequency of Use\_\_\_\_\_\_ Amount\_\_\_\_\_\_

8. Describe any physical problems you are experiencing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. List the age(s) that any of the following occurred in your life:

MEDICAL OTHER

\_\_\_\_\_liver disease \_\_\_\_\_juvenile delinquency \_\_\_\_\_childhood fears

\_\_\_\_\_kidney disease \_\_\_\_\_school phobia \_\_\_\_\_hyperactivity

\_\_\_\_\_pancreatitis \_\_\_\_\_drug/alcohol abuse \_\_\_\_\_running away

\_\_\_\_\_epilepsy \_\_\_\_\_teenage pregnancy \_\_\_\_\_truancy

\_\_\_\_\_thyroid disease \_\_\_\_\_bedwetting \_\_\_\_\_physical abuse

\_\_\_\_\_cancer \_\_\_\_\_sexual abuse

 \_\_\_\_\_incest

\_\_\_\_\_heart trouble \_\_\_\_\_anorexia

 \_\_\_\_\_rape

\_\_\_\_\_diabetes \_\_\_\_\_binge eating

 \_\_\_\_\_suicide attempts

\_\_\_\_\_venereal disease \_\_\_\_\_sexual problem \_\_\_\_\_self-mutilation

\_\_\_\_\_AIDS or HIV \_\_\_\_\_recent divorce \_\_\_\_\_behavior problems

1. What do you do for relaxation, fun, or pleasure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. What beliefs do you hold about yourself?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. How do other people describe you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Describe your current intimate relationship(s).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. What are your spiritual practices?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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15. Please list any past/current medical or psychological difficulties suffered by your children, siblings, parents, or grandparents (depression, anxiety, drug/alcohol abuse, suicide, or psychiatric hospitalization).

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My signature attests to the following: 1) I understand I am financially responsible for non-covered services; 2) I understand that Julia M. Hoffman is not “on-call” after office hours or on weekends; 3) I understand that Julia M. Hoffman is a sole practitioner in independent practice and is not part of a group practice.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Client)

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Client)