

BEHAVIORAL HEALTH-HEALTH QUESTIONNAIRE

San Luis Obispo Behavioral Health Department	<input type="checkbox"/> DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805) 781-4275 FAX (805) 781-1227	<input type="checkbox"/> MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177
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Medical Providers:

Check any of the providers listed below you currently receive services from or have received from in the last 5 years.

<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Private Community Physician	<input type="checkbox"/> Hospital Emergency Rooms
<input type="checkbox"/> Urgent Care Center	<input type="checkbox"/> Pain Management Services	<input type="checkbox"/> Specialty Medicine (i.e., Neurology, Cardiology, Endocrinology)
<input type="checkbox"/> Dentists	<input type="checkbox"/> Methadone Clinics	

General Health Information

1. Date you last saw a Doctor / Nurse Practitioner / Physician Assistant:	2. What was the purpose of the visit?	3. Date of your last physical exam?
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4. How many times have you visited an Emergency Room in the past 30 days?

5. How many days in past 30 have you stayed overnight in a hospital for physical health problems?

6. How many days in the past 30 have you experienced physical health problems?

7. Yes No Have you ever had surgery? If yes, please list:

8. Yes No Any other illness that requires frequent medical attention? If yes, please give details:

Allergies

9. Yes No Do you have any allergies? If yes, *what type of reaction did you have?* Fill out below-↓

Medication Allergies -

Food Allergies -

Other Allergies -

Medications

10. Please list any prescribed medications and over-the-counter medications you take regularly. (Include dosage and prescribing physician)

MEDICATION NAME	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN

11. Which Pharmacy do you use?

12. Are you currently experiencing or do you have any of the following?

Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> <input type="checkbox"/> Seizures
<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Headaches
<input type="checkbox"/> <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> <input type="checkbox"/> Weight Gain or Loss Recently
<input type="checkbox"/> <input type="checkbox"/> Bleeding Problems - Bruising Easily	<input type="checkbox"/> <input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> <input type="checkbox"/> Joint Pain or Stiffness	<input type="checkbox"/> <input type="checkbox"/> Blood Transfusions
<input type="checkbox"/> <input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Chest Pain (Angina)	<input type="checkbox"/> <input type="checkbox"/> Stroke - If yes, give details: _____
<input type="checkbox"/> <input type="checkbox"/> Excessive Heartburn or Abdominal Pains	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Cough, Persistent or Bloody	<input type="checkbox"/> <input type="checkbox"/> Artificial Joint
<input type="checkbox"/> <input type="checkbox"/> Chronic Back Pain	<input type="checkbox"/> <input type="checkbox"/> Head Injury - If yes, give details: details: _____
<input type="checkbox"/> <input type="checkbox"/> Tooth or Gum Problems	<input type="checkbox"/> <input type="checkbox"/> Cancer
<input type="checkbox"/> <input type="checkbox"/> Nausea or Vomiting	<input type="checkbox"/> <input type="checkbox"/> Chemotherapy/Radiation
<input type="checkbox"/> <input type="checkbox"/> Diarrhea, Constipation, Blood in Stools	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Dizziness or fainting	<input type="checkbox"/> <input type="checkbox"/> Asthma, Emphysema, or Chronic Bronchitis
<input type="checkbox"/> <input type="checkbox"/> Frequent or Bloody Urination	<input type="checkbox"/> <input type="checkbox"/> Anemia
<input type="checkbox"/> <input type="checkbox"/> Rashes	<input type="checkbox"/> <input type="checkbox"/> Heart Attack or Heart Problem - If yes, please give details:
<input type="checkbox"/> <input type="checkbox"/> Blurred or Double Vision	
<input type="checkbox"/> <input type="checkbox"/> Fever	

CLIENT NAME	CLIENT NUMBER
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13. Women Only				
Yes No <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If yes, due date: _____ <input type="checkbox"/> <input type="checkbox"/> Are you breastfeeding? If yes, date of delivery: _____ <input type="checkbox"/> <input type="checkbox"/> Have you had any miscarriages or abortions? If yes, please give details: _____ <input type="checkbox"/> <input type="checkbox"/> Do you have difficult periods? If yes, please give details: _____ At what age did you start your first period? _____ Date of last period: _____	Yes No <input type="checkbox"/> <input type="checkbox"/> Have you experienced any domestic violence? <input type="checkbox"/> <input type="checkbox"/> Do you have pain with intercourse? <input type="checkbox"/> <input type="checkbox"/> Have you had an abnormal mammogram or lump? If yes, please give details: _____ <input type="checkbox"/> <input type="checkbox"/> Have you had an abnormal PAP smear? If yes, please give details: _____ Date of last GYN exam: _____			
Communicable Diseases				
14. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been tested for TB? (Tuberculosis)?				
15. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a positive TB Test? Date of last TB Test or last chest X-ray: _____				
16. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been diagnosed with Hepatitis C? Date of last test: _____				
17. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been tested for any other liver disease?				
18. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been diagnosed with a Sexually Transmitted Disease (STD)?		Date of last STD Test?		
19. <input type="checkbox"/> Yes <input type="checkbox"/> No Did you get treated?				
20. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been tested for HIV?		Date of last HIV Test?		
21. <input type="checkbox"/> Yes <input type="checkbox"/> No Did you receive the test result?				
Mental Health				
22. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been diagnosed with a mental illness? If yes, what was your diagnosis? _____				
23. <input type="checkbox"/> Yes <input type="checkbox"/> No Did you receive treatment? If yes, please give details: _____				
24. <input type="checkbox"/> Yes <input type="checkbox"/> No How many times in the last 30 days have you received outpatient emergency services for mental health needs?				
25. <input type="checkbox"/> Yes <input type="checkbox"/> No How many days in the last 30 have you stayed 24 hours or more in a hospital or psychiatric health facility for mental health needs?				
26. <input type="checkbox"/> Yes <input type="checkbox"/> No In the past 30 days have you taken prescribed medication for mental health needs, including medication for anxiety?				
27. <input type="checkbox"/> Yes <input type="checkbox"/> No Past suicide attempts?		28. Date of last suicide attempt: _____		29. How many suicide attempts in your lifetime?
Alcohol and Other Drugs				
30. Do you use the following substances and how frequently:				
	Daily	Often	Sometimes	Date last used
Alcohol →				
Other substances →				
31. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever injected drugs?				
32. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you shared needles?				
33. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you shared cottons?				
34. <input type="checkbox"/> Yes <input type="checkbox"/> No How many days in the past 30 have you injected drugs?		Last time injected drugs: _____		
35. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever used SLO Co. Needle Exchange?				
36. <input type="checkbox"/> Yes <input type="checkbox"/> No Are you in withdrawal today? If yes, list from what substance(s)?				
37. <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures, delirium tremens? If yes, please give details: _____				
38. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had blackouts? If yes, please give details: _____				
39. <input type="checkbox"/> Yes <input type="checkbox"/> No Are you currently smoking / ingesting marijuana? →			Date last smoked/ingested marijuana: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No Medical Marijuana Card?				
40. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever overdosed on alcohol or other drugs?			If Yes, please give details: _____	
41. <input type="checkbox"/> Yes <input type="checkbox"/> No Do you currently use any tobacco products (cigarettes, electronic cigarettes, chew)?				
To the best of my knowledge the above information is accurate and true, and I will inform my provider of changes in my health or medications:				
Client Signature: _____			Date: _____	
Staff Signature: _____			Date: _____	
CLIENT NAME			CLIENT NUMBER	