BEHAVIORAL HEALTH-HEALTH QUESTIONNAIRE

San Luis Obispo Behavioral Health Department	☒ DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805) 781-4275 FAX(805) 781-1227	☐ MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177

Medical Providers:

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

☐Community Health Center ☐Urgent Care Center ☐Dentists
☐Pain Management Services ☐Methadone Clinic ☐Hospital Emergency Rooms
☐Private Community Physician ☐Specialty Medicine (i.e. Immunization, Neurology, Cardiology, and Endocrinology)

General Health Information

1. **Date of your last physical**?→	2. Date you last saw a doctor?→	3. What was the purpose of the visit?

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. ☐No ☐Yes Ever had surgery? **If YES, please list major surgeries:**

8 ☐No ☐Yes Are you able to perform activities of daily living: bathing, shopping, cleaning, use of transportation?

9 ☐No ☐Yes Do you have any religious, cultural, physical or other factors that might influence your care? **-if YES please list:**

10 ☐No ☐Yes History of any other illness that may require frequent medical attention? **Give Details:**

Allergies

11. ☐No ☐Yes Allergic to anything? - **If YES fill out below-↓** ***list allergy and your REACTION(i.e. hives rash, anaphylaxis, etc.)***

Medication Allergies

Food Allergies-

Other Allergies ***(animals, chemicals, etc.)***

Medications

12. ☐**NO** ☐ **YES** **MEDICATIONS → If YES**

List any prescription meds (including hormone replacement, birth control and psychiatric and/or anxiety meds)

List any Over-the-Counter medications you take regularly (such vitamins, food supplements, ibuprophen, Tylenol, Tums, Pepto Bismol, etc)

If more space needed, add separate sheet.

MEDICATION NAME	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN

What Pharmacy do you use?

13. Are you currently experiencing any of the following?

No Yes	No Yes	No Yes
☐ ☐ Swollen ankles	☐ ☐ Jaundice-frequent yellowing of skin	☐ ☐ Sinus problems
☐ ☐ Bleeding problems, bruising easily	☐ ☐ Joint pain or stiffness	☐ ☐ Swallowing difficulty
☐ ☐ Chest Pain (angina)	☐ ☐ Excessive heartburn or abdominal pains	☐ ☐ Thirst-excessive
☐ ☐ Cough; persistent or bloody	☐ ☐ Chronic back pain	☐ ☐ Tooth or gum problems
☐ ☐ Diarrhea, constipation, Blood in stools	☐ ☐ Nausea and vomiting	☐ ☐ Urination frequent or bloody
☐ ☐ Dizziness or fainting	☐ ☐ Rashes	☐ ☐ Vision-blurred or double vision
☐ ☐ Fever	☐ ☐ Seizures	☐ ☐ Weight gain or loss recently
☐ ☐ Headaches	☐ ☐ Shortness of breath	

14. Do you have or have you had any of the following

No Yes	No Yes	No Yes
☐ ☐ Arthritis	☐ ☐ Anemia	☐ ☐ High Blood Pressure
☐ ☐ Artificial Joint	☐ ☐ Blood Transfusions	☐ ☐ Low Blood Pressure
☐ ☐ Asthma, Emphysema or chronic bronchitis	☐ ☐ Cancer	☐ ☐ Stroke- If yes give details:
☐ ☐ Diabetes	☐ ☐ Chemotherapy/Radiation	

15. No☐ Yes☐ **Head injury** resulting in loss of consciousness **give details**:

16. No☐ Yes☐ **Heart Attack or Heart Problem**-give details: **Date of heart attack**:

CLIENT NAME	**CLIENT NUMBER**

17. Women Only

No	Yes		No	Yes	
☐	☐	Pregnant? Due Date_____	☐	☐	Any current or past domestic abuse?
☐	☐	Breast Feeding	☐	☐	Do you have pain with intercourse?
☐	☐	Have you had any miscarriages or abortions?	☐	☐	Abnormal mammogram or lump? Date:_____
☐	☐	Do you have difficult periods?	☐	☐	Abnormal PAP? Date:_____

Age you started your first period? _____

Date of last period: _____

Date of last GYN exam: _____

Communicable Diseases

18. ☐No ☐Yes Have you ever been tested for TB? (Tuberculosis)

19. ☐No ☐**Yes→ Have you ever had a positive TB Test?→** **Date of last TB Test or last chest X-ray:**

20. ☐No ☐Yes Have you been diagnosed with Hepatitis C? Date of last test: _____

21. ☐No ☐Yes Have you been tested for any other liver disease ? **Specify**:

22. ☐No ☐Yes Have you been diagnosed with a Sexually Transmitted Disease (STD)?

23. ☐No ☐Yes Did you get treated?

Date of last STD Test?

24. ☐No ☐Yes Have you been tested for HIV?

☐No ☐Yes Did you receive the test result?→

Date of last HIV Test:

Mental Health

25. ☐No ☐Yes Have you ever been diagnosed with a mental illness?

☐No ☐Yes Were you treated? If YES → ☐Outpatient ☐Inpatient ☐NA

What was your diagnosis?

26. ☐ How many times in the past 30 days have you received outpatient emergency services for mental health needs?

27. ☐ How many days in the past 30 days have you stayed 24 hours or more in a hospital or psychiatric facility for mental health needs?

28. ☐No ☐Yes In the past 30 days, have you taken prescription medication(s) for mental health needs? *include anxiety meds-* ***list meds on question 12.***

29. ☐No ☐Yes **Past suicide attempts? →** **Date of most recent attempt: →** **How many attempts in your lifetime?**

Alcohol and Other Drugs

30. **Do you use any of the following substances and how frequently?**	**Daily**	**Past week**	**Past 30 days**	**Past Year**	**Never**
Alcohol→					
Drugs→					
Prescription Meds NOT prescribed for me→					

31. ☐No ☐Yes Have you ever injected drugs? **If yes have you** → ☐Shared needles? → ☐Shared cottons?

32. ☐ How many days in the past 30 have you injected drugs? **Last time injected:** **Have you used SLO Co. Needle Exchange?**

33. ☐No ☐Yes Have you just used any form of drugs or alcohol? **If yes when?**

34. ☐No ☐Yes Do you feel you are in withdrawal today? **If Yes, from what substance(s)?**

36. ☐No ☐Yes Have you had blackouts? **If yes, how many times, how frequent?**

37. ☐No ☐Yes Are you currently smoking/ingesting marijuana? →

☐No ☐Yes **Do you have a Medical Marijuana Card?**

Date you last ingested Marijuana

38. ☐No ☐Yes Have you ever overdosed on alcohol or other drugs? **If Yes → What?** **When?**

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 ONLY BELOW

PHYSICIAN REVIEW AND RECOMMENDATIONS	**STAFF ACTIONS**
☐ **Client meets medical necessity**	☐ **ROI and Referral sent**
☐ **Client to be referred for physical exam**	☐ **ROI and Medical Records Request sent**
☐ **Client indicates physical exam within 12 months, request medical records**	
Physicians Signature _____**Date**_____	**Staff** _____**Date**_____
CLIENT NAME	**CLIENT NUMBER**