Lisa Schwellinger, LLC

Health History Questioner

Patient Name:

1. Please list all current medications or supplements you are taking for either physical or emotional difficulties:

2.Allergy(Medications): ____

3. Current Medical/Emotional Conditions: (Please check all that apply.)

Anxiety
Allergies
Asthma
Arthritis
Back Trouble
High Blood Pressure
Cancer
Chronic Pain
Depression
Diabetes

Epilepsy/Seizure Disorder
Frequent Constipation
Frequent Headaches
Fatigue
Hay Fever
Heart Problems
Hearing Problems
Irritable Bowels
Sleep Disturbances
Stomach Problems

Skin Problems
Sexually Transmitted Diseases
Vision Problems
Weight Loss
Smoker/ Amount per Day

Other ___________________

Is there any family history of the above conditions? Yes - No (If Yes, please explain

4. Name of Medical Doctor: ______________________________ Last Physical Exam: ___________________

Are you currently being treated? Yes - No Problem:

Date Last Seen:

5. Have you ever previously been seen for outpatient therapy? (Please list previous therapists and reason seen.)

Have you been previously hospitalized for emotional difficulties? (Please list hospitals and approximate dates.)

Have you previously been treated for chemical dependency? (Please list facilities and approximate dates.)

6. Do any family members have chemical dependency, alcoholism or emotional problems?

7. Do you use alcohol/drugs, tobacco, laxatives or caffeine? List type and amounts per day:

8. Are you having problems in your sexual relationship? If so, describe: