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Health Concern Questionnaire

The information you provide in this questionnaire will help bring me up to speed so that I can be an effective part of your treatment team. If you are hesitant to complete any part of this form, please feel free to leave it blank and we will discuss it during our first meeting.

Identifying Information:

Name:_____ Date: _____

Social Security Number: _____ Date of Birth:_____

About You:

Gender: ☐ Female ☐ Male ☐ Intersex ☐ Transgender _____

Relationship Status:

	How Long?		How Long?
☐ Single, never legally married or committed		☐ Separated	_____
☐ Married	_____	☐ Divorced	_____
☐ Coupled	_____	☐ Widowed	_____

With which group do you most identify?

☐ African descent	_____	☐ Native American	_____
☐ Asian	_____	☐ Pacific Islander	_____
☐ Latina/o	_____	☐ Southeast Asian	_____
☐ Middle-Eastern	_____	☐ Other	_____
☐ Multicultural	_____		_____

What language do you primarily speak at home? _____

Do you have any religious or spiritual practices? ☐ Yes ☐ No

If yes, please describe:_____

Education/Academic History:

Highest Level of Education Completed	Where?	When?
_____	_____	_____

Did you have any learning or behaviour problems? If yes, please explain: _____

_____

Which best describes your current living situation?

☐ I live alone ☐ I live with other people. Please list those with whom you live:

Name	Age	Relationship

How has your health or pain concern been affected by your home situation? How has your home situation been affected by your health or pain condition?

_____

_____

_____

_____

_____

_____

_____

Which best describes your current employment situation:

☐ Employed full-time
☐ Full-time student
☐ Volunteer
☐ Disabled due to: _____
☐ Unemployed for other reasons: _____

☐ Military, Active duty
☐ Part-time student
☐ Retired

☐ Employed part-time
☐ Homemaker, caregiver
☐ Retired
☐ Unemployed due to health problems

If employed, please indicate:

Job Title: _____

Responsibilities: _____

Current Level of Satisfaction ☐ High ☐ Moderate ☐ Poor

Level of Satisfaction Prior to Health or Pain Concern ☐ High ☐ Moderate ☐ Poor

Your current employment situation: (continued)

Do you receive any of the following?

	Related to your health or pain concern?	
☐ SDI (State Disability Insurance)	☐ Yes	☐ No
☐ SSI (Supplementary Security Income)	☐ Yes	☐ No
☐ Worker's Compensation	☐ Yes	☐ No
☐ Unemployment Insurance	☐ Yes	☐ No

Is there a Worker's Compensation claim or litigation involved with your case?

☐ No
☐ No, but claim or litigation is being considered
☐ Yes, but already settled. Date: _____
☐ Yes, currently involved:
Attorney Name: _____ Telephone: _____

Address: _____

_____

Worker's Comp Company: _____ Telephone: _____

Claim Adjuster: _____ Telephone: _____

Are you currently experiencing any of the following stressful situations?

Couples/Relationship stress	☐ Yes	☐ No
Stress at Work	☐ Yes	☐ No
Stress at School	☐ Yes	☐ No
Financial Stress	☐ Yes	☐ No
Stress With Your Family	☐ Yes	☐ No

Please describe your habits as indicated below:

In a typical week, how many days did you exercise? _____ days

For how long do you exercise per day? _____ minutes per day

In a typical week, how many days did you consume alcohol? _____ Days

In a typical day, how many drinks do you consume? _____ drinks
(1 drink = one 12 oz beer, 4 oz wine, or 1 oz hard liquor)

Have you ever participated in a substance abuse program? ☐ Yes ☐ No

If yes, which one? _____

Please describe your habits as indicated below: (continued)

In a typical week, how many days did you restrict your eating? _____ days

In a typical week, how many days did you eat significantly more than you intended? _____ days

Have you ever participated in an eating disorders program? ☐ Yes ☐ No

If yes, which one? _____

How much nicotine do you use in a day?_____in a day. Please indicate which ones:

☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ Nicotine patch ☐ Nicotine gum

How much caffeine do you use in a day?_____ in a day. Please indicate which ones:

☐ Coffee ☐ Colas ☐ Chocolate ☐ Mello Yello/Mountain Dew, etc.
☐ Teas ☐ Energy Drinks ☐ Other:_____

Please describe your usual sleep patterns:

In general, how many hours of sleep do you get per night? _____ hours

Do you ever stop breathing, or has someone told you that you stop breathing when you sleep? ☐ Yes ☐ No

Has anyone told you that you snore or have you awakened yourself at night with your own snoring? ☐ Yes ☐ No

In what position do you sleep? (Check all applicable answers):

☐ On my back ☐ On my stomach ☐ On my side ☐ I change positions often

How do you feel when you first wake up?

☐ Refreshed and rested ☐ Somewhat tired or groggy ☐ Very tired or groggy

Do you find yourself nodding off during the day or taking naps? ☐ Yes ☐ No

Please indicate any health concerns you have *other than those that bring you here today*:

Health Concern	Current Status	Current Treatment(s)	Health Care Professional

In the past month, including today, indicate how often you have experienced the following:

	Constantly	A lot	As often as not	Occasionally	Never
Sadness	☐	☐	☐	☐	☐
Discouragement	☐	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	☐
Worthlessness	☐	☐	☐	☐	☐
Resignation	☐	☐	☐	☐	☐
Loss of pleasure	☐	☐	☐	☐	☐
Loss of satisfaction in life	☐	☐	☐	☐	☐
Feeing that life is not worth living	☐	☐	☐	☐	☐
Worry	☐	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐	☐
Frustration	☐	☐	☐	☐	☐
Feeling frightened	☐	☐	☐	☐	☐
Resentfulness	☐	☐	☐	☐	☐
Anger	☐	☐	☐	☐	☐
Elation	☐	☐	☐	☐	☐
Satisfaction with life	☐	☐	☐	☐	☐
Contentment	☐	☐	☐	☐	☐
Happiness	☐	☐	☐	☐	☐
Hopefulness	☐	☐	☐	☐	☐
Peacefulness	☐	☐	☐	☐	☐

About Your Health or Pain Concern:

How long have you had trouble with this concern? _____

Which of the following best describes how your health or pain condition began:

☐ Accident at Home
☐ Accident at Work
☐ Work Related
☐ Motor Vehicle Accident
☐ After An Illness
☐ After A Head Injury
☐ After Surgery
☐ Just Began
☐ Came on Gradually

What is your understanding of what is causing your health or pain concern?

_____

_____

_____

_____

_____

About Your Health or Pain Concern: (continued)

On the scale below, please circle the number that best describes your pain or discomfort on an average day where 0 = No pain or discomfort at all and 10 = Pain or discomfort is so intense that you lose consciousness after just a few minutes.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Lose consciousness after a few minutes

Please circle the number that best describes your pain or discomfort on a bad day:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Lose consciousness after a few minutes

Please circle the number that best describes your pain or discomfort on a good day:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Lose consciousness after a few minutes

In the past week how many bad days have you had? _____ bad days

Are you aware of any of the following factors relieving your health or pain condition?

	Never	Rarely	Sometimes	Usually	Always
Take Medication	☐	☐	☐	☐	☐
Massage	☐	☐	☐	☐	☐
Change position	☐	☐	☐	☐	☐
Lie down	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Sexual Activity	☐	☐	☐	☐	☐
Drink fluids (water, juice)	☐	☐	☐	☐	☐
Pressing on area	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐
Hot bath or Shower	☐	☐	☐	☐	☐
Ice	☐	☐	☐	☐	☐
Distracting activity	☐	☐	☐	☐	☐
Rest	☐	☐	☐	☐	☐
Eat	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

About Your Health or Pain Concern: (continued)

Are you aware of any of the following factors triggering or aggravating your health or pain concern?

	Never	Rarely	Sometimes	Usually	Always
Food	☐	☐	☐	☐	☐
Hunger	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐
Smoking	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Sexual Activity	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐
Pollen Count	☐	☐	☐	☐	☐
Jaw Clenching	☐	☐	☐	☐	☐
Neck Movements	☐	☐	☐	☐	☐
Coughing	☐	☐	☐	☐	☐
Sneezing	☐	☐	☐	☐	☐
Life Stress	☐	☐	☐	☐	☐
Relaxation	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Anger	☐	☐	☐	☐	☐
Flicker	☐	☐	☐	☐	☐
Glare	☐	☐	☐	☐	☐
Eyestrain	☐	☐	☐	☐	☐
Noise	☐	☐	☐	☐	☐
Humidity	☐	☐	☐	☐	☐
High Temperature	☐	☐	☐	☐	☐
Low Temperature	☐	☐	☐	☐	☐
Other:_____	☐	☐	☐	☐	☐

During the past month, how much did your health or pain concern interfere with the following activities:

	Not at all	A little	Moderately	A lot
Going to work	☐	☐	☐	☐
Performing household chores	☐	☐	☐	☐
Doing yard work or shopping	☐	☐	☐	☐
Socializing with friends	☐	☐	☐	☐
Participating in recreation	☐	☐	☐	☐
Having sexual relations	☐	☐	☐	☐
Physically exercising	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Eating	☐	☐	☐	☐

About Your Health or Pain Concern: (continued)

	Never	Sometimes	Frequently	Always
How often do you lie down because of your health or pain condition?	☐	☐	☐	☐
When you have pain or discomfort, how often is your significant other/family member/friend supportive and encouraging?	☐	☐	☐	☐
When you have pain or discomfort, how often does your significant other/family member/friend ignore you or become angry?	☐	☐	☐	☐
How often has there been conflict or disharmony between you and your significant other/family member/friend since the start of your health or pain condition?	☐	☐	☐	☐

Does your health or pain condition ever disturb your sleep? If yes, please indicate how:

- ☐ Delay getting to sleep
- ☐ Awaken early in the morning
- ☐ Awaken during the night
- ☐ Does not disturb sleep

Please describe any periods of time in which your health or pain condition either significantly diminished or worsened:

_____

_____

_____

_____

Are there any events or circumstances that you think may have contributed to your health or pain condition beginning? (stressful events, head or neck trauma, menarche, contraceptive use, pregnancy, exertion, other)

_____

_____

_____

_____

About Your Health or Pain Concern: (continued)

List all current prescription and over the counter medications taken for this condition:

Medication	Dosage (Per Day)	Side Effects (if any)	How Effective Is It?	Prescribed By

List all past prescription and over the counter medications taken for this condition:

Medication	Dosage (Per Day)	How Effective Was It?	Why Did You Discontinue This Medication?

List all current prescription and over the counter medications taken but unrelated to this condition:

Medication	Dosage (Per Day)	Side Effects (if any)	Reason for Prescription	Prescribed By

List all vitamin supplements or herbal remedies you are currently taking for any condition:

Vitamin supplement or herbal remedy	Dosage (Per Day)	Reason You Are Taking This Supplement or Remedy	Recommended or Prescribed By

Do you now have, have you ever had, or has any family member related to you by blood had:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart disease
- ☐ Mitral valve prolapse
- ☐ Other heart murmur
- ☐ Heart arrhythmia
- ☐ Angina
- ☐ Functional cardiac pain
- ☐ Anemia
- ☐ Stroke
- ☐ Transient Ischemic Attachs
- ☐ Fainting (syncope)
- ☐ Dizziness (vertigo)
- ☐ Raynaud's disease
- ☐ Menstrual irregularities
- ☐ Tingling in hands or feet
- ☐ Cancer
- ☐ Diabetes (insulin dependent)
- ☐ Diabetees (non-insulin dependent)
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Repetitive Abdominal Pain (RAP)
- ☐ Colitis
- ☐ Gastritis
- ☐ Ulcer
- ☐ Heartburn
- ☐ Eating Disorder
- ☐ Headache
- ☐ Migraine
- ☐ Tinnitis
- ☐ TMJ or bruxism
- ☐ TMD
- ☐ Repetitive Strain Injury (RSI)
- ☐ Chronic back pain
- ☐ Other Chronic Pain
- ☐ Allergies
- ☐ Dermatitis
- ☐ Muscle spasms
- ☐ EB Virus (Mono)
- ☐ Chronic Tiredness
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ Hyperventilation
- ☐ Asthma
- ☐ Panic Attacks
- ☐ Depression
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ PMS
- ☐ Chronic vaginal yeast
- ☐ Cystitis
- ☐ Herpes

About Your Health or Pain Concern: (continued)

Please indicate other treatments you have tried and indicate their effectiveness:

Treatment	Currently Trying	Tried In The Past	Lasting Benefits	Temporary Benefits	No Effect At All	Condition Worsened
Acupressure						
Acupuncture						
Alexander Technique						
Bioenergetics						
Biofeedback						
Qi Gung						
Chiropractor						
Cranio-sacral						
Egoscue Method						
Exercise						
Feldenkrais						
Flower Essences						
Hanna Somatics						
Healer (alternative)						
Heat						
Ice						
Guided Imagery						
Herbal Remedies						
Homeopathy						
Hypnosis						
Massage						
Medicine Man						
Myotherapy						
Nerve Blocks						
Physical Therapy						
Psychotherapy						
Relaxation						
Meditation						
Mindfulness						
Shaman						
T'ai Chi						
Therapeutic Touch						
Yoga						
Other:						

About Your Health or Pain Concern: (continued)

Please indicate below how satisfied you are with the diagnosis and treatment of this condition:

	Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Dissatisfied	Very Dissatisfied
My medical provider's diagnosis of my condition	☐	☐	☐	☐	☐
My medical provider's treatment of my condition	☐	☐	☐	☐	☐
The benefits and side effects of my current medication(s)	☐	☐	☐	☐	☐
The overall medical care of my health or pain condition	☐	☐	☐	☐	☐

Please check the box(es) that best describes your current attitude towards your health or pain condition and your treatment:

☐ I believe there is a medication or other medical treatment that will cure all or most of my condition.

☐ I am not sure if there is anything that will cure all or most of my health or pain condition.

☐ I believe I may have this health or pain condition for a long time, perhaps for the rest of my life.

☐ My thoughts, emotions, and behaviors have little or no influence on my health or pain condition.

☐ My thoughts, emotions, and behaviors have some impact on my health or pain condition.

☐ I can modify my health or pain condition by changing my thoughts, managing my emotions, or changing my behaviors.

☐ I am basically satisfied with my current medications for my health or pain condition and want to continue taking them as I currently am doing.

☐ I am wondering if my medications are really all that helpful.

☐ I am interested in changing my current medications for my health or pain condition.

☐ I am interested in stopping or decreasing my current medications for my health or pain condition.

☐ I am *not* interested in learning or practicing self-management, non-medication methods to manage my health or pain condition.

☐ I would like to get some training or suggestions on how to best self-manage my health or pain condition

About Your Health or Pain Concern: (continued)

Other observations, notes, or comments (optional):

Please keep track of your pain or discomfort experiences from now until the time we meet on this diary form, or on another of your choosing that contains at least the same information.

Pain or Discomfort Diary

Date	Time	Pain Rating (0=None, 10=Lose Consciousness)	Action Taken To Get Relief	Effect
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		
		0 1 2 3 4 5 6 7 8 9 10		

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