Pathways Counseling
Joel D. Wyrtzen, LPC
phone (512) 697-9613 **fax** (512) 215-4639
www.pathwaysaustin.com

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*							☐ M ☐ F	**DOB:**
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	**Name of Spouse/Partner**:	
Previous Therapist:							**How did you hear about us?**	

PERSONAL HEALTH HISTORY

Are you under the care of a physician at this time? If so, Name:		Specialization:
Mailing Address Street City Zip Code	Phone:	Cell:
	Email:	How do you prefer to be contacted?
	Employer:	Occupation:

What brings you into therapy today?

Hospitalizations for psychiatric care or substance abuse		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Dosage	Frequency Taken
Allergies to medications?		

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider (Pathways Counseling) about your risk of this illness?				☐ Yes	☐ No

MENTAL HEALTH (USE SPACE TO ELABORATE IF NECCESARY)		
Are you in counseling voluntarily?	☐ Yes	☐ No
Do you live alone?	☐ Yes	☐ No
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No
Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider (Pathways Counseling)?	☐ Yes	☐ No

FAMILY HEALTH HISTORY (OPTIONAL):
SOMETIMES FAMILY HEALTH HISTORY/CONDITIONS CONTRIBUTE TO THE STRESSORS OR TRIGGERS IN YOUR LIFE.

	AGE	SIGNIFICANT HEALTH (PHYSICAL OR MENTAL) PROBLEMS		AGE	SIGNIFICANT HEALTH (MENTAL OR PHYSICAL) PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Is there anything else you would like me to know about you?

Emergency Contact:

Name:	Relationship:
Contact Information (phone, email):	Does this person know that you are in counseling?

Insurance Information

Carrier/Insurance Company:	ID # (or SS#) :
Subscriber Name and birth date:	Are you planning to file for Social Security Disability? Y / N Describe: