VIRGINIA BEACH COUNSELING SERVICES
CLIENT AND FAMILY HEALTH QUESTIONNAIRE

Client's Name: _____ Date: _____

Please complete the following survey of health conditions that may have affected you or your family

- ❑ Have you or anyone in your family had a problem or condition in the following areas?

	Self	Family	Comments
Allergies			
Drugs or Medication Reaction			
Tics or Tremors			
Seizures			
Asthma			
Thyroid Problems			
Heart Disease			
Epilepsy			
Diabetes			
Chronic Pain Syndrome			
6 Month Post Partum			
HIV			
Hepatitis			
TB			
STD’s			
Pregnancy			
Abnormal Bleeding			
Blackouts			
High Blood Pressure			
Kidney Problems			
Cancer			

- ❑ Is there a family history of:

	Self	Family	Comments
Drug Abuse			
Bipolar Disorder			
Suicide			
Mental Retardation			
Schizophrenia			
Eating Disorders			
ADD/ADHD			
Depression			

Client and Family Health Questionnaire – Page 2

❑ Are you or anyone in your family affected by handicaps or restrictions on physical activity?

Self	Others	Comments

❑ Any past hospitalizations for illness or surgeries?

Self	Others	Comments

❑ Chronic health conditions or health problems by siblings, parents or other household members?

Self	Others	Comments

❑ Current or past problems with alcohol abuse, drug abuse, prescription medication abuse, or abuse of over-counter- medications?

Who: _____
Resolved or ongoing _____
_____

Client's Name: _____ Client's Account Number: _____

Please list all current medications – prescription, over-the-counter, supplements, homeopathic remedies, and herbal:

Name of Medication	Dose You Take	When do you take it?

Who is prescribing the medicine?

_____

Do you have an advanced directive? i.e. living will, do not resuscitate orders

_____

Client's Name: _____ Client's Account Number: _____