

<b>BEHAVIORAL HEALTH-HEALTH QUESTIONNAIRE</b>			
<b>San Luis Obispo Behavioral Health Department</b>		<input checked="" type="checkbox"/> DAS 2180 Johnson Ave, San Luis Obispo, CA 93401 Phone: (805) 781-4275 FAX( 805) 781-1227	<input type="checkbox"/> MH 2178 Johnson Ave, San Luis Obispo, CA 93401 Phone: (800) 838-1381 FAX (805) 781-1177
<b>Medical Providers:</b>			
<i>Check any of the providers listed below you currently receive services from or have received from in the last 5 years.</i>			
<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Urgent Care Center	<input type="checkbox"/> Dentists	
<input type="checkbox"/> Pain Management Services	<input type="checkbox"/> Methadone Clinic	<input type="checkbox"/> Hospital Emergency Rooms	
<input type="checkbox"/> Private Community Physician	<input type="checkbox"/> Specialty Medicine (i.e. Immunization, Neurology, Cardiology, and Endocrinology)		
<b>General Health Information</b>			
1. <b>Date of your last physical?</b> →		2. <b>Date you last saw a doctor?</b> →	3. <b>What was the purpose of the visit?</b>
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.	<input type="checkbox"/> No <input type="checkbox"/> Yes Ever had surgery? <b>If YES, please list major surgeries:</b>		
8.	<input type="checkbox"/> No <input type="checkbox"/> Yes Are you able to perform activities of daily living: bathing, shopping, cleaning, use of transportation?		
9.	<input type="checkbox"/> No <input type="checkbox"/> Yes Do you have any religious, cultural, physical or other factors that might influence your care? <b>-if YES please list:</b>		
10.	<input type="checkbox"/> No <input type="checkbox"/> Yes History of any other illness that may require frequent medical attention? <b>Give Details:</b>		
<b>Allergies</b>			
11. <input type="checkbox"/> No <input type="checkbox"/> Yes Allergic to anything? - If YES fill out below: <b>list allergy and your REACTION(i.e. hives rash, anaphylaxis, etc.)</b>			
<b>Medication Allergies</b>			
<b>Food Allergies-</b>			
<b>Other Allergies ( animals, chemicals, etc.)</b>			
<b>Medications</b>			
12. <input type="checkbox"/> NO <input type="checkbox"/> YES <b>MEDICATIONS → If YES</b>			
<b>List any prescription meds</b> (including hormone replacement, birth control and psychiatric and/or anxiety meds)			
<b>List any Over-the-Counter medications you take regularly</b> (such vitamins, food supplements, ibuprophen, Tylenol, Tums, Pepto Bismol, etc)			
<b>If more space needed, add separate sheet.</b>			
MEDICATION NAME	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN
<b>What Pharmacy do you use?</b>			
<b>13. Are you currently experiencing any of the following?</b>			
No Yes <input type="checkbox"/> <input type="checkbox"/> Swollen ankles <input type="checkbox"/> <input type="checkbox"/> Bleeding problems, bruising easily <input type="checkbox"/> <input type="checkbox"/> Chest Pain (angina) <input type="checkbox"/> <input type="checkbox"/> Cough; persistent or bloody <input type="checkbox"/> <input type="checkbox"/> Diarrhea, constipation, Blood in stools <input type="checkbox"/> <input type="checkbox"/> Dizziness or fainting <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> Headaches	No Yes <input type="checkbox"/> <input type="checkbox"/> Jaundice-frequent yellowing of skin <input type="checkbox"/> <input type="checkbox"/> Joint pain or stiffness <input type="checkbox"/> <input type="checkbox"/> Excessive heartburn or abdominal pains <input type="checkbox"/> <input type="checkbox"/> Chronic back pain <input type="checkbox"/> <input type="checkbox"/> Nausea and vomiting <input type="checkbox"/> <input type="checkbox"/> Rashes <input type="checkbox"/> <input type="checkbox"/> Seizures <input type="checkbox"/> <input type="checkbox"/> Shortness of breath	No Yes <input type="checkbox"/> <input type="checkbox"/> Sinus problems <input type="checkbox"/> <input type="checkbox"/> Swallowing difficulty <input type="checkbox"/> <input type="checkbox"/> Thirst-excessive <input type="checkbox"/> <input type="checkbox"/> Tooth or gum problems <input type="checkbox"/> <input type="checkbox"/> Urination frequent or bloody <input type="checkbox"/> <input type="checkbox"/> Vision-blurred or double vision <input type="checkbox"/> <input type="checkbox"/> Weight gain or loss recently	
<b>14. Do you have or have you had any of the following</b>			
No Yes <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> Artificial Joint <input type="checkbox"/> <input type="checkbox"/> Asthma, Emphysema or chronic bronchitis <input type="checkbox"/> <input type="checkbox"/> Diabetes	No Yes <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Blood Transfusions <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Chemotherapy/Radiation	No Yes <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Stroke- If yes give details:	
15. No <input type="checkbox"/> Yes <input type="checkbox"/> <b>Head injury</b> resulting in loss of consciousness <b>give details:</b>			
16. No <input type="checkbox"/> Yes <input type="checkbox"/> <b>Heart Attack or Heart Problem</b> -give details: <b>Date of heart attack:</b>			
<b>CLIENT NAME</b>			<b>CLIENT NUMBER</b>

17. Women Only						
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Pregnant? Due Date _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Any current or past domestic abuse?	
<input type="checkbox"/>	<input type="checkbox"/>	Breast Feeding	<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain with intercourse?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any miscarriages or abortions?	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal mammogram or lump? Date: _____	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficult periods?	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal PAP? Date: _____	
Age you started your first period? _____			Date of last GYN exam: _____			
<b>Communicable Diseases</b>						
18. <input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever been tested for TB? (Tuberculosis)						
19. <input type="checkbox"/> No <input type="checkbox"/> Yes → Have you ever had a positive TB Test? → Date of last TB Test or last chest X-ray: _____						
20. <input type="checkbox"/> No <input type="checkbox"/> Yes Have you been diagnosed with Hepatitis C? Date of last test: _____						
21. <input type="checkbox"/> No <input type="checkbox"/> Yes Have you been tested for any other liver disease? Specify: _____						
22. <input type="checkbox"/> No <input type="checkbox"/> Yes Have you been diagnosed with a Sexually Transmitted Disease (STD)?					Date of last STD Test?	
23. <input type="checkbox"/> No <input type="checkbox"/> Yes Did you get treated?						
24. <input type="checkbox"/> No <input type="checkbox"/> Yes Have you been tested for HIV?			Date of last HIV Test: _____			
<input type="checkbox"/> No <input type="checkbox"/> Yes Did you receive the test result? →						
Mental Health						
25. <input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever been diagnosed with a mental illness?					What was your diagnosis?	
<input type="checkbox"/> No <input type="checkbox"/> Yes Were you treated? If YES → <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> NA						
26.	<input type="checkbox"/>	How many times in the past 30 days have you received outpatient emergency services for mental health needs?				
27.	<input type="checkbox"/>	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. <input type="checkbox"/> No <input type="checkbox"/> Yes In the past 30 days, have you taken prescription medication(s) for mental health needs? <i>include anxiety meds- list meds on question 12.</i>						
29. <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever injected drugs? <b>If yes have you</b> → <input type="checkbox"/> Shared needles? → <input type="checkbox"/> Shared cottons?						
32.	<input type="checkbox"/>	How many days in the past 30 have you injected drugs?	Last time injected:	Have you used SLO Co. Needle Exchange?		
33. <input type="checkbox"/> No <input type="checkbox"/> Yes Have you just used any form of drugs or alcohol? <b>If yes when?</b>						
34. <input type="checkbox"/> No <input type="checkbox"/> Yes Do you feel you are in withdrawal today? <b>If Yes, from what substance(s)?</b>						
36. <input type="checkbox"/> No <input type="checkbox"/> Yes Have you had blackouts? <b>If yes, how many times, how frequent?</b>						
37. <input type="checkbox"/> No <input type="checkbox"/> Yes Are you currently smoking/ingesting marijuana? →			Date you last ingested Marijuana			
<input type="checkbox"/> No <input type="checkbox"/> Yes Do you have a Medical Marijuana Card?						
38. <input type="checkbox"/> No <input type="checkbox"/> 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		
<input type="checkbox"/> Client meets medical necessity				<input type="checkbox"/> ROI and Referral sent		
<input type="checkbox"/> Client to be referred for physical exam				<input type="checkbox"/> ROI and Medical Records Request sent		
<input type="checkbox"/> Client indicates physical exam within 12 months, request medical records						
Physicians Signature _____		Date _____		Staff _____ Date _____		
CLIENT NAME				CLIENT NUMBER		