Solution Focused · Affordable Fee · Healthy Lifestyles · Recovery · Spiritual Support

Visions Counseling Inc.

Wendie Martell-Williams, LCSW, SAC

History Questionnaire

Patient's Name: (Last) ____________________ (First) ____________________ (M.I.) _____

Patient's Birth Date: ___ ___ / ___ ___ / ___ ___ ___ ___ Age: ______ Sex: M F

Patient's Education Level: PK K 1 2 3 4 5 6 7 8 9 10 11 12 12+ BS MA PHD

Patient's School or Employer: ____

Patient's Occupation: ____

Patient's Favorite Hobby/Activity: ____

Who is completing this form? ____

What is your relationship to the patient? ____

Name: ____

Address: ____

____

____

Home Telephone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Cell Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Work Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Fax: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

E-Mail Address: ______________________________

How did you hear about Visions Counseling? ______________________________

____

What is your goal in coming here? How can we be most useful to you? ______________________________

____

____

Who lives in the same house/apartment with the patient?

Name	Relationship to Patient	Age	Occupation/Grade In School

N2355 Smith Road Merrill WI, 54452 • 715-551-1970 Office/Cell • 715-539-3580 Fax

What family members are significantly involved in the patient's life but do not live with the patient?

Name	Relationship to Patient	Age	Occupation/Grade In School

Is there a family history of mental health or drug and alcohol problems? Yes No Please explain (who and what): ______________________________

____

____

Is there a family history of suicide or homicide? Yes No Please explain: ______________________________

____

Has the patient ever attempted suicide? Yes No Please explain (When and How): ____________

____

____

Has the patient ever been hospitalized for mental health or drug and alcohol problems? Yes No
Please Explain (When, Where, and Why): ______________________________

____

____

Has the patient ever been in therapy before? Yes No Please Explain (When, With Whom, and Why):

____

____

Patient's Height: ____________ Patient's Weight: ____________

Primary Care Physician: ______________________________

Office Location: ______________________________

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

What medical problems, if any, is the patient currently having? ______________________________

____

____

What medications are the patient currently taking?

Medication	Dosage	Prescribing Physician

Date of last physical exam: ___ ___ / ___ ___ / ___ ___ ___ ___

Reason for exam: ______________________________

Allergies: ______________________________

Hospitalizations for Operations, Injury, or Serious Illness (When, Where, and Why): ________________

____

____

Does the patient:

Smoke? Yes No How much/often? ________________

Chew Tobacco? Yes No How much/often? ________________

Drink Caffeine? Yes No How much/often? ________________

Drink Alcohol? Yes No Which Kinds? Beer Wine Hard Liquor

How much? 0-2 Drinks 3-5 Drinks 6-9 Drinks 10+ Drinks

How often? Daily 3-5 Times/Week 1-2 Times/Week 1-2 Times/Month

Use Drugs? Yes No Which Kinds? ________________

____

How much/often? ________________

____

Do you sometimes drink more alcohol or use more drugs than planned? Yes No

Have family or friends ever been concerned about your alcohol or drug use? Yes No

Have you ever been arrested (including OWIs) for alcohol or drug related offenses? Yes No

Have you ever been treated for alcohol or drug use/abuse/dependence? Yes No

Have you ever overdosed? Yes No

Have you ever had blackouts (loss of memory) ? Yes No

Please check any of the following diseases the patient has had:

- ☐ Tuberculosis
- ☐ Chronic Bronchitis
- ☐ Pneumonia
- ☐ Strep Infection
- ☐ Emphysema
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ Asthma
- ☐ Allergies
- ☐ Anemia
- ☐ Liver Disease
- ☐ Stomach Ulcer
- ☐ Nervous Disorder
- ☐ Thyroid Disorder
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Cancer
- ☐ Epilepsy
- ☐ Bleeding Tendencies
- ☐ Stroke
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Kidney Disorder
- ☐ High Blood Pressure
- ☐ Sexually Transmitted Disease
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ TMJ
- ☐ Carpal Tunnel Syndrome

Please check any of the following complaints the patient is currently experiencing:

- ☐ Excessive Fatigue
- ☐ Swollen Glands
- ☐ Loss of Hearing
- ☐ Ringing in Ears
- ☐ Difficulty Swallowing
- ☐ Chronic Cough
- ☐ Blood with Cough
- ☐ Abnormal Chest X-ray
- ☐ Wheezing
- ☐ Pain in Chest
- ☐ Shortness of Breath
- ☐ Numbness/Tingling in hands or feet
- ☐ Palpitation of Heart
- ☐ Dizziness
- ☐ Balance Problems
- ☐ Sexual Difficulties
- ☐ Head Injury
- ☐ Heart Murmur
- ☐ Other Heart Trouble
- ☐ 10+ Pound Weight Gain or Loss
- ☐ Recurrent Abdominal Pain
- ☐ Tarry/Black Stools
- ☐ Frequent Nausea or Vomiting
- ☐ Changes in Bowel Habits
- ☐ Rectal Bleeding
- ☐ Difficult or Painful Urination
- ☐ Blood in Urine
- ☐ Swelling in Ankles and Legs
- ☐ Easy Bleeding or Bruising
- ☐ Frequent Headaches
- ☐ Blurred Vision
- ☐ Nervous Breakdown
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts

Women Only:

- ☐ Vaginal Bleeding or Discharge (Not part of period)
- ☐ Enlarged Glands (lumps) in neck, armpit, or groin
- ☐ Pregnant

Men Only:

- ☐ Genital Pain, Sores, or Infection
- ☐ Enlarged Glands (lumps) in neck, armpit, or groin