Department for Children and Families
Rehabilitation Services

9/93

Health Assessment Questionnaire

Name:_____ Date of Birth: _____

Address:_____ Height:_____Weight_____

	Explain any "Yes" answers	**Reported Medical History**		
I have had:		Yes	No	(problem - who treated - when)
1.	Problems with eyes, ears, nose, throat	□	□	
2.	Dizziness, fainting, blackout, convulsions, stroke, paralysis,	□	□	
3.	A head injury	□	□	
4.	Persistent bronchitis, asthma, emphysema, tuberculosis, or other problems with chest or lungs	□	□	
5.	High blood pressure, chest pain, heart attack, rheumatic fever, heart murmur, or other problems with heart or blood vessels	□	□	
6.	Ulcer, hernia, colitis, intestinal bleeding, or other problems with stomach, intestines, liver, or gall bladder	□	□	
7.	Problems with kidneys, bladder, prostate, reproductive organs, or venereal disease	□	□	
8.	Diabetes, thyroid, pituitary, adrenal, or other gland problems	□	□	
9.	Arthritis, low back pain, or other problems with spine, back or joints	□	□	
10.	Loss or paralysis of limb or other body parts	□	□	
11.	Tumors, leukemia, or cancer	□	□	
12.	Allergies, anemia, skin problems	□	□	
13.	Mental or emotional problems	□	□	
14.	Problems with reading, arithmetic, writing or speech	□	□	
15.	Problems with alcohol or drugs	□	□	
16.	Treatment for any physical or mental problems	□	□	
17.	Prescriptions for any drugs or medications	□	□	
18.	A brace, prosthesis, hearing aid or other device	□	□	

My recent medical records may be obtained from:
Name of Physician/Hospital: _____
Address: _____
Date of Last Exam: _____Reason:_____

I certify that all of the information I have given is true, correct and complete to the best of my knowledge.

_____ _____ _____ _____
Client's Signature Date Counselor's Signature Date