HEALTH Questionnaire Form

First Name	Middle	Last Name	DOB	Age
Height:		Weight:		

Who referred you to Worthington Consultation? (how did you find out about us)
Thank you for trusting us with your care, what problems can we help you with? *(Reason for the visit)*
Any current mental health or addictions problems (diagnoses)?
Medications: *(for mental health or addictions)*

Current Mental Health Symptoms [Check all that apply]:		
Depression	Mood swings	Seeing things
Hopeless feeling	Racing Thoughts	Hearing things
Suicidal thoughts	Irritable mood	Paranoia
Problems sleeping	Problem concentrating	Excessive worrying

Any physical health problems (diagnoses)?
Medications: *(for physical health)*
Medication Allergies:

X **PATIENT'S SIGNATURE** (or Legal Guardian):	**Date:**

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