Karen A. Mahan, LCSW
dba Transitions Equine LLC

_____
NAME

Health History Questionnaire

1. Please list all current medications you are taking for either physical or emotional difficulties:

_____

_____

2. Allergy (Medications): _____
3. Current Medical/Emotional Conditions (please check):

___Anxiety	___ Diabetes	___Sleep Disturbance
___Allergies	___Epilepsy/Seizure Disorder	___Stomach Problems
___Asthma	___Frequent Constipation	___Skin Problems
___Arthritis	___Frequent Headaches	___Sexually Transmitted Disease
___Back Trouble	___Fatigue	___Vision Problems
___High Blood Pressure	___Hay Fever	___Weight Loss/Gain
___Cancer	___Heart Problems	___Smoker/Amount per day___
___Depression	___Irritable Bowels	___Other_____

Is there any family history of the above conditions?_____

4. Medical Doctor_____Last Physical Exam_____

Currently being treated?_____Problem:_____Date Last Seen:_____

5. Have you ever previously been seen for outpatient therapy? (list previous therapists/reasons)

_____

_____

Have you been previously hospitalized for emotional difficulties? (list previous hospitals/dates)

_____

Have you previously been treated for chemical dependency? (List hospitals/dates)

_____

6. Do any family members have chemical dependency, alcoholism or emotional problems? List:_____

7. Do you use sedatives, alcohol, tobacco, laxative, caffeine? Type and amount per day:. List:_____

8. Are you having problems in your sexual relationship? _____