

## BIOPSYCHOSOCIAL QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive understanding of your life experience, background, and medical health issues. Responding to these questions as completely as you can will help your clinician gain an understanding of the problems for which you are seeking help and of important events in your life. Some of the questions deal with alcohol and drug use, depression and suicide, and being the victim of a violent crime, including sexual assault. It is possible that these questions might make you feel uncomfortable. You may skip any question you do not wish to answer.

Your responses will remain strictly confidential and will become part of your medical record. Please return this form when completed by mailing it in the self addressed envelope; faxing it to 307-265-4480; or bringing it with you at your first appointment. Thank you.

|   |             |               |              |
|---|-------------|---------------|--------------|
| Your name (first and last)              | Age         | Date of Birth | Today's Date |
| Home address, city, state, and zip code |             |               |              |
| Home Phone:                             | Work Phone: | Cell Phone:   |              |

Which number should be called if it is necessary to change an appointment or leave a message?  Home  Work  Cell

### CURRENT CONCERNS

|   |
|---|
| Briefly describe the problem you would like to address:   |
| What factors led you seek treatment at this time?<br><input type="checkbox"/> Legal Problems <input type="checkbox"/> Health Problems <input type="checkbox"/> Financial Problems <input type="checkbox"/> Relationship Problems <input type="checkbox"/> School Problems <input type="checkbox"/> Work problems<br><input type="checkbox"/> Other (please explain) |
| Who referred you to Wyoming Recovery?   |
| List the substances you have used in the past seven days:   |
| List the substances you have used in the past 24 hours:   |

### PREVIOUS TREATMENT

| Tell us about your previous mental health or substance abuse treatment |                                      |  |                       |
|--|--------------------------------------|--|-----------------------|
| Date of Treatment  | Name of Treatment Provider or Center | Reason and type of Treatment (Residential, Detox, Outpatient, etc) | Response to Treatment |
|  |                                      |  |                       |
|  |                                      |  |                       |
|  |                                      |  |                       |
|  |                                      |  |                       |

What was your longest period of sobriety? \_\_\_\_\_ How long ago did it end? \_\_\_\_\_

| SUBSTANCE USE/ADDICTION HISTORY  |   |   |
|--|---|---|
| <b>Check each substance that you are presently using or have used in the past</b>  |   |   |
| <input type="checkbox"/> Alcohol (including beer and wine)   | <input type="checkbox"/> Depressants (Valium, Xanax, etc)     | <input type="checkbox"/> Stimulants (speed, Meth, etc)                    |
| <input type="checkbox"/> Cocaine (Powder, crack, etc)  | <input type="checkbox"/> Marijuana (spice)                    | <input type="checkbox"/> Hallucinogens (Acid, Mushrooms, Ecstasy, Peyote) |
| <input type="checkbox"/> Inhalants (poppers, paint, glue, etc)   | <input type="checkbox"/> Nicotine (smoked, chewed, smokeless) | <input type="checkbox"/> Opiates (Pain meds, heroin, oxy, Percocet)       |
| <input type="checkbox"/> other: List   | <input type="checkbox"/> other: List                          | <input type="checkbox"/> other: List                                      |
| <b>For each substance that you checked list the following (use back of page if necessary)</b>  |   |   |
| <b>Substance:</b>  | Age first used:   | Date last used:   |
| Current Craving: <input type="checkbox"/> none <input type="checkbox"/> moderate <input type="checkbox"/> strong Method: <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Snorted <input type="checkbox"/> Injected <input type="checkbox"/> Other (specify) |   |   |
| Past pattern of use (frequency and quantity)   |   |   |
| Current pattern of use (frequency and quantity)  |   |   |
| <b>Substance:</b>  | Age first used:   | Date last used:   |
| Current Craving: <input type="checkbox"/> none <input type="checkbox"/> moderate <input type="checkbox"/> strong Method: <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Snorted <input type="checkbox"/> Injected <input type="checkbox"/> Other (specify) |   |   |
| Past pattern of use (frequency and quantity)   |   |   |
| Current pattern of use (frequency and quantity)  |   |   |
| <b>Substance:</b>  | Age first used:   | Date last used:   |
| Current Craving: <input type="checkbox"/> none <input type="checkbox"/> moderate <input type="checkbox"/> strong Method: <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Snorted <input type="checkbox"/> Injected <input type="checkbox"/> Other (specify) |   |   |
| Past pattern of use (frequency and quantity)   |   |   |
| Current pattern of use (frequency and quantity)  |   |   |
| <b>Substance:</b>  | Age first used:   | Date last used:   |
| Current Craving: <input type="checkbox"/> none <input type="checkbox"/> moderate <input type="checkbox"/> strong Method: <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Snorted <input type="checkbox"/> Injected <input type="checkbox"/> Other (specify) |   |   |
| Past pattern of use (frequency and quantity)   |   |   |
| Current pattern of use (frequency and quantity)  |   |   |
| <b>Substance:</b>  | Age first used:   | Date last used:   |
| Current Craving: <input type="checkbox"/> none <input type="checkbox"/> moderate <input type="checkbox"/> strong Method: <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Snorted <input type="checkbox"/> Injected <input type="checkbox"/> Other (specify) |   |   |
| Past pattern of use (frequency and quantity)   |   |   |
| Current pattern of use (frequency and quantity)  |   |   |
| Have you ever-Injected Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which ones?   |   |   |
| What is your substance of choice?  |   |   |

|  |  |  |
|--|--|--|
| Do you have a history of any of these other addictions? if so check:   |  |  |
| <input type="checkbox"/> Codependency  | <input type="checkbox"/> Overeating/eating disorder              | <input type="checkbox"/> Workaholic  |
| <input type="checkbox"/> Gambling  | <input type="checkbox"/> Spending                                | <input type="checkbox"/> Shopping  |
| <input type="checkbox"/> Video games   | <input type="checkbox"/> Internet surfing                        | <input type="checkbox"/> Pornography   |
| <input type="checkbox"/> Sexual  | <input type="checkbox"/> Other: _____                            |  |
| Have you ever received treatment for any of the above addictions, if so, when and where?   |  |  |
| <b>Triggers to use</b><br>Check which factors lead you to use  |  |  |
| <input type="checkbox"/> Boredom   | <input type="checkbox"/> Fear                                    | <input type="checkbox"/> Stress  |
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Hopelessness                            | <input type="checkbox"/> Other (please explain)  |
| <input type="checkbox"/> Need to relax   | <input type="checkbox"/> Loneliness                              | <input type="checkbox"/> Panic attacks   |
| <input type="checkbox"/> Inhibition  | <input type="checkbox"/> Social anxiety                          |  |
| <b>CONSEQUENCES AS A RESULT OF DRUG/ALCOHOL USE (CHECK ALL THAT APPLY)</b>   |  |  |
| <input type="checkbox"/> Hangovers   | <input type="checkbox"/> Left school                             | <input type="checkbox"/> Using/carrying a weapon   |
| <input type="checkbox"/> DTs/Shakes  | <input type="checkbox"/> Incarcerations                          | <input type="checkbox"/> Assaulting others   |
| <input type="checkbox"/> Blackouts   | <input type="checkbox"/> DUI's                                   | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Binges  | <input type="checkbox"/> Reckless driving                        | <input type="checkbox"/> Sleep problems  |
| <input type="checkbox"/> Overdoses   | <input type="checkbox"/> Auto accidents                          | <input type="checkbox"/> Liver disease   |
| <input type="checkbox"/> Increased Tolerance   | <input type="checkbox"/> Breaking the law                        | <input type="checkbox"/> Hep C or HIV/AIDS   |
| <input type="checkbox"/> Delusions/hallucinations  | <input type="checkbox"/> Unplanned pregnancy                     | <input type="checkbox"/> GI or esophageal bleeding   |
| <input type="checkbox"/> Falling down when drunk   | <input type="checkbox"/> Rape                                    | <input type="checkbox"/> Sexual acting out   |
| <input type="checkbox"/> Loss of Control   | <input type="checkbox"/> STD's                                   | <input type="checkbox"/> Drug dealing  |
| <input type="checkbox"/> Loss of self respect  | <input type="checkbox"/> Arrests                                 | <input type="checkbox"/> Relationship problems   |
| <input type="checkbox"/> Other: please explain:  |  |  |
| <b>OBSTACLES TO RECOVERY</b>   |  |  |
| Do you believe any of the following will make it more difficult for you to stop using alcohol or drugs?  |  |  |
| <input type="checkbox"/> Living with someone who uses alcohol or drugs   | <input type="checkbox"/> Having friends who use alcohol or drugs |  |
| <input type="checkbox"/> Experiencing a great deal of job or home stress   | <input type="checkbox"/> Being depressed or anxious              |  |
| <input type="checkbox"/> Having strong cravings for alcohol or drugs   | <input type="checkbox"/> Having few or no hobbies                |  |
| Do you have any communication difficulties which could affect your recovery effort (ex speech, visual, or hearing impairment)? If so- what   |  |  |
| During treatment, what support systems (family, friends, neighbors, church, etc) will be available to help you with your recovery?   |  |  |
| <b>FINANCIAL AND LEGAL STATUS</b>  |  |  |
| Do you have any current legal problems (describe)?   |  |  |
| Any past legal charges (describe)?   |  |  |
| Any past court ordered treatment? If yes who was it ordered by, what was the offense, and what was the length of time?   |  |  |
| Are you experiencing any current financial problems? <input type="checkbox"/> No <input type="checkbox"/> Yes (describe)   |  |  |
| <b>ENVIRONMENT AND HOME</b>  |  |  |
| Marital Status:<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Living as married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other |  | Who is currently living with you?  |
| List the names and ages of your children:  |  | Do you have custody of your minor children? <input type="checkbox"/> yes <input type="checkbox"/> no |
| What childcare arrangements do you have?   | How many close friends do you have?                              | Are you satisfied with this number?  |
| Has there been violence/physical abuse in your current relationships? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  | Your past relationships? <input type="checkbox"/> Yes <input type="checkbox"/> No                    |
| What is the primary language used in your home?  |  | Secondary language?  |

| <b>SOCIAL</b>   |                  |   |                 |  |
|---|------------------|---|-----------------|--|
| Rate how supportive you feel the following people are in your life using a scale from 1-5 with 5 being strong:  |                  |   |                 |  |
|   | Immediate Family |   | Extended Family | Friends  |
|   | School           |   | Work            | Religious/Spiritual Advisors   |
| Other:  |                  |   |                 |  |
| <b>SEXUAL HISTORY</b>   |                  |   |                 |  |
| What is your sexual orientation?  |                  | Are you comfortable with your sexual orientation?<br><input type="checkbox"/> Yes <input type="checkbox"/> No (explain) |                 | Do you practice safe sex? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Type of contraception: |
| Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                  |   |                 |  |
| If there is significant information regarding your sexual history – List here   |                  |   |                 |  |
| <b>VOCATIONAL, EDUCATIONAL, AND MILITARY HISTORY</b>  |                  |   |                 |  |
| Where are you employed?   |                  | Job Title?  |                 | Do you like your job? <input type="checkbox"/> Yes <input type="checkbox"/> No (explain)                     |
| Have you been in the military?<br><input type="checkbox"/> No <input type="checkbox"/> Yes – (list branch)  |                  | Highest Rank?   |                 | Type of Discharge?   |
| Highest Level of Education: <input type="checkbox"/> Did not complete high school <input type="checkbox"/> Completed College <input type="checkbox"/> Technical Training <input type="checkbox"/> Obtained GED<br><input type="checkbox"/> Completed high school <input type="checkbox"/> Completed graduate school |                  |   |                 |  |
| Do you have difficulties reading or writing? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                  |   |                 |  |
| Have you ever been diagnosed with a learning disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you have problems in school (if yes explain below)? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                  |   |                 |  |
|   |                  |   |                 |  |

| <b>RELIGION AND SPIRITUAL ORIENTATION</b>   |   |  |
|---|---|--|
| Is spirituality a significant part of your life?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | What denomination are you affiliated with – if any? | Do you attend regularly?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| How would you describe your spirituality?   |   |  |
| <b>LEISURE AND RECREATION</b>   |   |  |
| List your interests or hobbies:   |   |  |
| What social activities do you participate in?   |   |  |
| <b>ETHNIC AND CULTURAL INFORMATION</b>  |   |  |
| What is your ethnic group? <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Caucasian <input type="checkbox"/> Other: |   |  |
| What if any, cultural beliefs do you have that could be relevant to your treatment?   |   |  |
| What are your strengths, such as talents, skills or personal characteristics?   |   |  |
|   |   |  |

### PSYCHOLOGICAL

Check if you have a history of or have experienced any of the following problems:

|  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Depressed Mood              | <input type="checkbox"/> Intrusive memories, thoughts | <input type="checkbox"/> Avoiding thoughts, feelings | <input type="checkbox"/> Avoiding people, places |
| <input type="checkbox"/> Nightmares                  | <input type="checkbox"/> Flashbacks                   | <input type="checkbox"/> Numbing/detachment          | <input type="checkbox"/> Irritability            |
| <input type="checkbox"/> Trouble displaying emotions | <input type="checkbox"/> History of depressed mood    | <input type="checkbox"/> History of animal abuse     | <input type="checkbox"/> History of tantrums     |
| <input type="checkbox"/> History of hurting others   | <input type="checkbox"/> Other: describe              |  |  |

What are your sleep patterns?  Normal  Sleeping too much  Sleeping too little

What is your ability to concentrate?  Normal  Difficulty concentrating

Would you describe your energy level as:  Low  Average/ Normal  High

Have you ever been suicidal?  Yes  No Have you ever attempted suicide  Yes  No

Do you have suicidal thoughts or plans now?  Yes  No If you answered yes, please explain:

### FAMILY HISTORY

Are your parents still living?  Yes  No (if no, when and how old were they when they died)?

Please list the names and ages of your siblings; if they are living; and if deceased their age at death

| Name | Age | Living   | How would you describe your relationship? |
|------|-----|--|---|
|      |     | <input type="checkbox"/> Yes <input type="checkbox"/> No (age at death?) |   |
|      |     | <input type="checkbox"/> Yes <input type="checkbox"/> No (age at death?) |   |
|      |     | <input type="checkbox"/> Yes <input type="checkbox"/> No (age at death?) |   |
|      |     | <input type="checkbox"/> Yes <input type="checkbox"/> No (age at death?) |   |
|      |     | <input type="checkbox"/> Yes <input type="checkbox"/> No (age at death?) |   |
|      |     | <input type="checkbox"/> Yes <input type="checkbox"/> No (age at death?) |   |
|      |     | <input type="checkbox"/> Yes <input type="checkbox"/> No (age at death?) |   |

Would you describe your childhood home as :  Loving  Comfortable  Chaotic  Abusive  Supportive  Other (describe below)

What is your families ethnic/ancestral/tribal background and what meaning does this have in your life?

#### Family History of Substance Abuse and Mental Illness (place a check in the column if condition is present)

|  | Mother | Father | Siblings | Grandparents | Children | Other |
|--|--------|--------|----------|--------------|----------|-------|
| Alcohol  |        |        |          |              |          |       |
| Suicide  |        |        |          |              |          |       |
| History of Mental Illnesses/ Problems such as: |        |        |          |              |          |       |
| Depression                                     |        |        |          |              |          |       |
| Schizophrenia                                  |        |        |          |              |          |       |
| Bipolar Disorder                               |        |        |          |              |          |       |
| Alzheimer's                                    |        |        |          |              |          |       |
| Anxiety  |        |        |          |              |          |       |
| ADHD   |        |        |          |              |          |       |
| Learning Disorders                             |        |        |          |              |          |       |
| School Behavior Problems                       |        |        |          |              |          |       |
| Incarceration                                  |        |        |          |              |          |       |
| Other  |        |        |          |              |          |       |

| <b>HISTORY OF TRAUMA</b>  |  |
|---|--|
| While you were growing up, during the first 18 years of life:   |  |
| Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you or act in a way that made you afraid that you might be physically hurt?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you or ever hit you so hard that you had marks or were injured?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way or attempt to actually have oral, anal, or vaginal intercourse with you?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did you often or very often feel that : No one in your family loved you or thought you were important or special or that your family didn't look out for each other, feel close to or support each other?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did you often or very often feel that: You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you or your parents were too drunk or high to take care of you, or take you to the doctor if you needed?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Were your parents ever separated or divorced?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was your mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at her; or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard; or ever repeatedly hit at least or threatened with a gun or knife? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did you live with anyone who was a problem drinker or alcoholic or who used drugs?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did a household member go to prison?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

## MEDICAL HISTORY

|   |                |  |
|---|----------------|--|
| Your name (first and last)  |                |  |
| Name of your Primary Care Provider:   |                | Phone:   |
| Date of Last Visit:   | Reason:        | Date of Last Physical?   |
| Please list any medical problems that doctors/medical providers have diagnosed:   |                |  |
| List any current medical problems you are concerned about:  |                |  |
| Have you had any worrisome physical symptoms when using alcohol or drugs?   |                |  |
| <b>List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (use other side of page if needed)</b>                            |                |  |
| Name of Drug  |                | Name of Drug   |
|   |                |  |
|   |                |  |
|   |                |  |
| <b>List any medication Allergies</b>  |                |  |
| Name the Medication   |                | Reaction you experience  |
|   |                |  |
|   |                |  |
| <b>List any Allergies to food/environment, etc</b>  |                |  |
| Name the Allergen   |                | Reaction you experience  |
|   |                |  |
|   |                |  |
| <b>List any surgeries you have had (use other side of page if needed)</b>   |                |  |
| Year  | Surgery/Reason | Outcome since surgery  |
|   |                | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same |
|   |                | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same |
|   |                | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same |
| <b>Other hospitalizations (other than for addiction or substance abuse treatment)</b>   |                |  |
| Year  | Reason         | Outcome since hospitalization  |
|   |                | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same |
|   |                | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same |
|   |                | <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same |
| Date of last skin test (PPD) for tuberculosis: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Never had one |                |  |
| Date of Last HIV test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Never had one                         |                |  |
| Date of Last Hepatitis test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Never had one                   |                |  |
| Have you ever had a blood transfusion? <input type="checkbox"/> Yes (date: _____ ) <input type="checkbox"/> No  |                |  |

|   |                          |   |                          |
|---|--------------------------|---|--------------------------|
| Have you ever shared needles? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                          |   |                          |
| <b>REVIEW OF SYSTEMS</b>  |                          |   |                          |
| <b>Please answer questions with a <input checked="" type="checkbox"/> if your answer is yes</b>   |                          |   |                          |
| Have you ever had jaundice?   | <input type="checkbox"/> | Do you have difficulty walking?   | <input type="checkbox"/> |
| Have you had abnormal bruising, bleeding or healing?  | <input type="checkbox"/> | Have you ever had pitch black stools or blood in your stools?                     | <input type="checkbox"/> |
| Do you have problems with clear vision, distance or reading?  | <input type="checkbox"/> | Have you ever vomited blood or 'coffee grounds'?                                  | <input type="checkbox"/> |
| Do you have a serious problem hearing?  | <input type="checkbox"/> | Do you have frequent heart burn or acid reflux?                                   | <input type="checkbox"/> |
| Have you had serious nose bleeds?   | <input type="checkbox"/> | Have you had any kind of liver disease?   | <input type="checkbox"/> |
| Have you had hoarseness or change in your voice that does not go away in a day or two?  | <input type="checkbox"/> | Have you been diagnosed with pancreatitis   | <input type="checkbox"/> |
| Have you had difficulty chewing or swallowing solid food?   | <input type="checkbox"/> | Have you had stomach or duodenal ulcers?  | <input type="checkbox"/> |
| Have you had problems with nausea or vomiting?  | <input type="checkbox"/> | Have you had any inflammatory bowel disease?                                      | <input type="checkbox"/> |
| Have you been diagnosed or do you feel you have an eating disorder?   | <input type="checkbox"/> | Have you had problems with constipation?  | <input type="checkbox"/> |
| Have you been diagnosed with diabetes?  | <input type="checkbox"/> | Have you had problems with diabetes   | <input type="checkbox"/> |
| Do you suffer from chronic pain of your bones, muscles, or joints?  | <input type="checkbox"/> | Do you use laxatives more than twice a week?                                      | <input type="checkbox"/> |
| Do you have COPD or asthma requiring frequent medication?   | <input type="checkbox"/> | Do you have blood in your urine?  | <input type="checkbox"/> |
| Do you have difficulty breathing when climbing stairs?  | <input type="checkbox"/> | Do you have any difficulty or pain with urination?                                | <input type="checkbox"/> |
| Have you had a cough lasting over two weeks?  | <input type="checkbox"/> | Do you have any difficulties with sexual function?                                | <input type="checkbox"/> |
| Do you experience shortness of breath?  | <input type="checkbox"/> | Have you ever been diagnosed with a sexually transmitted disease?                 | <input type="checkbox"/> |
| Have you ever had a serious heart problem?  | <input type="checkbox"/> | Is there a chance you might be pregnant now?                                      | <input type="checkbox"/> |
| Do you have chest pain, tightness, or pressure with exertion?   | <input type="checkbox"/> | Have you ever had a significant head injury?                                      | <input type="checkbox"/> |
| Have you been diagnosed with high blood pressure?   | <input type="checkbox"/> | Do you have frequent or severe headaches?   | <input type="checkbox"/> |
| Have you had serious or persistent fluid retention?   | <input type="checkbox"/> | Have you ever had a seizure or loss of consciousness ?                            | <input type="checkbox"/> |
| Have you had episodes of rapid or irregular heart beats?  | <input type="checkbox"/> | Have you ever had a problem with weakness or paralysis of part of your body?      | <input type="checkbox"/> |
| Have you ever fallen or hurt yourself after drinking or using drugs?  | <input type="checkbox"/> | Have you ever had any type of cancer?   | <input type="checkbox"/> |
| Do you have sores or growths in your mouth or throat or elsewhere that concern you?   | <input type="checkbox"/> | Have you had persistent or recurring bleeding? If yes...where:                    | <input type="checkbox"/> |
| <b>If you answered "YES" to any of the questions above, or if you have other medical problems that bother you that are not listed on this page, please describe below:</b>  |                          |   |                          |
|   |                          |   |                          |
| <b>NUTRITION</b>  |                          |   |                          |
| What is your current weight? _____ What is your usual weight? _____ Height? _____   |                          |   |                          |
| Have you gained or lost 10 or more pounds in the past month?<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>Could you be pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/><br>Are you on a modified diet? Yes <input type="checkbox"/> No <input type="checkbox"/><br>How would you describe your appetite? Good <input type="checkbox"/> Average <input type="checkbox"/> Poor <input type="checkbox"/><br>Has your appetite changed recently? Yes <input type="checkbox"/> No <input type="checkbox"/> |                          | <b>If you answered yes to any of these questions, please clarify:</b><br><br><br> |                          |