PATIENT HEALTH QUESTIONNAIRE

Date:_____

Last Name: _____; First Name: _____; Middle Initial:__
Date of Birth: ___/___/_____
Address:_____
Phone Number: (Home)_____(Cell)_____
Which number may we leave confidential voicemail? _____

Marital Status: Married_____; Divorced____; Single____; Widowed_____
Employer:_____
Children(s) ages: _____
Level of Education: High School____; College____; Graduate degree____

What is your goal for treatment? _____

Health History (answer Y or N and describe)

Diabtes _____
Heart Disease_____
Digestive Disease_____
Reproductive issues_____
Headaches_____
Hepatitis (type)_____
Respiratory issues_____
Infectious Diseases_____
Auto-immune diseases_____
Vision problems_____
Stroke_____
Insomnia_____
Surgeries: _____

Head injuries_____
Broken bones_____

Psychiatric History:

Outpatient treatment - Dates from and to: _____
Inpatient treatment – Dates from and to:_____
Past Psychiatric Medications: _____

_____

Past Psychiatric Diagnoses:_____

Current Medications

Psychiatric:_____

Medical:_____

History of Trauma/Abuse:_____

_____

_____

Family Psychiatric History:_____

_____

_____

Substance Use:

Alcohol Frequency: Daily_____; Once or twice/week____: Rare:_____

Amount and type per use_____

Marijuana Frequency: Daily____; Once or twice/week_____; Rare_____

Amount per use_____

Other drugs: Meth_____; Opioids_____; Cocaine_____;

Hallucinogens_____

Amount per use and route:_____

History of Substance Abuse Treatment: Dates from & to:_____

_____

Emergency Contact:

Name:_____

Phone Number:_____

I understand that all of my health information is strictly confidential and protected under Federal HIPPA Law. _____(initial)

I agree to pay for services as per agreement with Dr. Cox's office. _____(initial)

I agree to pay for all appointments missed without 24 hours notice unless on a monthly fee. _____(initial)

_____

Signature

Date:_____

Print name____