HEALTH SCREENING
& HEALTH HISTORY QUESTIONNAIRE

LIFE STRATEGY CONSULTANTS, LLC

Professional Counseling, Consulting & Educational Services

Client Name _____ Date of Birth ____/____/____

GENERAL HEALTH AND MENTAL HEALTH INRORMATION

1. Are you currently experiencing overwhelming sadness, grief, or depression? ❑Yes ❑No

   If yes, for approximately how long? _____

2. Are you currently experiencing anxiety, panic attacks, or suffer from phobias? ❑Yes ❑No

   If yes, when did you begin experiencing this? _____

3. How would you rate your current physical health? Date of last Physical Exam: _____

   ❑ Poor Explain: _____

   ❑ Fair Explain: _____

   ❑ Good Explain: _____

   ❑ Excellent Explain: _____

4. Are you currently being treated for any specific illness or disease? ❑Yes ❑No

   If yes, please explain: _____

5. Are you satisfied with your quality of sleep? ❑Yes ❑No

   If no, please explain (e.g. difficulty falling asleep, early waking, …) _____

6. How many times per week do you exercise (on average)? _____
7. Do you smoke? ❑Yes ❑No What product(s) and how much? _____
8. Do you drink alcohol? ❑Yes ❑No What product(s) and how much? _____
9. What is your current weight? _____ What is your current blood pressure? _____

SELF/FAMILY MEMBER MENTAL HEALTH HISTORY

10. Have you or your extended family ever been diagnosed/treated for any of the following:

Alcohol/Substance Addiction	❑Yes	❑No	❑Self	❑Family	Relationship: _____
Anxiety	❑Yes	❑No	❑Self	❑Family	Relationship: _____
Depression	❑Yes	❑No	❑Self	❑Family	Relationship: _____
Domestic Violence	❑Yes	❑No	❑Self	❑Family	Relationship: _____
Eating Disorders	❑Yes	❑No	❑Self	❑Family	Relationship: _____
Obsessive Compulsive Behavior	❑Yes	❑No	❑Self	❑Family	Relationship: _____
Schizophrenia	❑Yes	❑No	❑Self	❑Family	Relationship: _____
Suicide Attempts/Completion	❑Yes	❑No	❑Self	❑Family	Relationship: _____

_____ _____

CLIENT SIGNATURE DATE

Revised April 2018