ETCH
EARLY TREATMENT & COGNITIVE HEALTH

General Health Questionnaire

Date________________ ID#__________Name____
DOB_________________ Age_________________ ❒ Male ❒ Female ❒ Other
Allergies: _________ Medication ___________Food ________Environmental
Please list:____
____
Primary Care Provider____________________________________ PCP's Phone #____________________________
Clinic ___________________________________ City____

Ht. ___________ Wt. __________ Waist_________ b/p ______________ P _______

Do you smoke cigarettes?_______ If yes, amount?_____day/week At what age did you begin smoking?_______
Are you currently exposed to second hand smoke?_______ Would you like to quit smoking?___________

Do you drink alcohol?____________ If yes, amount? __________daily, weekly, or monthly? At what age did you begin drinking?_________ Have you ever experienced a blackout?____________

Do you take street drugs?_____________ If yes, what is your drug of choice?______________________________
Which drug do you take most often?_________________ Amount?____________ Frequency?________________
What route(s) do you use? (i.e. smoking, snorting, injecting, etc…)____
At what age did you begin using? _____________ Have you ever sought and/or received treatment ?___________
If so, where?______________________________________ Was it effective?__________________________________

Do you gamble?_______ If yes, what is your favorite game?____
Has anyone ever told you this is a problem for you?___________ Have you ever sought and/or received treatment?___________ If so, where?____

Please check all that apply:

	Self		Self	Family	Relationship
Frequent headaches	❒	Cardiovascular disease	❒	❒	______________
Dizziness or fainting	❒	Kidney disease	❒	❒	______________
Nausea and/or vomiting	❒	Liver disease	❒	❒	______________
Diarrhea or constipation	❒	Diabetes Mellitus	❒	❒	______________
Frequent voiding	❒	Thyroid dysfunction	❒	❒	______________
Frequent thirst	❒	Other______________	❒	❒	______________

Which meals do you regularly eat during the day? ___________ breakfast _________ lunch ________ dinner
With whom do you eat your meals?____
Throughout the day, how often do you snack?_________ Are there certain times during the day when you are more apt to snack than others?_______ When?____

What type of foods do you snack on?____

What type of beverages do you drink?____
How much of each type do you drink on an average day?____
____
Do you drink water on a regular basis?_________ If so, how much every day?_________________________

How do you sleep during the night?__________________________ Do you have trouble falling asleep?___________
Staying asleep? ______________ Waking too early?____________ On average, approximately how many hours do you sleep each night?_________ Do you remember your dreams?_____________

Do you take walks?____________ Ride a bicycle?_______ Jog?___________ Swim?__________ Run up & down stairs throughout the day?____________ Do you have a regular exercise routine?____________________
If so, what is it?____
Are you currently taking any medications, vitamins, or supplements? If so, please list_______________________
____

Are you sexually active?______________ How many partners have you had in the past year? _________________
What form, if any, of protection do you use?____
Have you ever been treated for a STI?_________If female, do you believe you are currently pregnant?__________
If so, how far into your pregnancy are you?____________

Would you like a copy of this form for your personal records?__________

For office use only:____
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