

HEALTH QUESTIONNAIRE

Kelly Baskind Ph.D.

DATE: _____

NAME: _____ DOB: _____

You have seen a psychologist or other mental health professional in the past?

Do you Smoke? YES / NO If yes, how much? _____

How often? _____

Do you drink alcohol? YES / NO If yes, how frequently and how much?

Do you use street drugs? (i.e. marijuana, cocaine, etc.) YES / NO _____

Please list any medical conditions for which you are currently being treated.

Please list all medications you are currently taking. _____
