Department of Health Care Services
Licensing and Certification Branch, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

CLIENT HEALTH QUESTIONAIRE

HEALTH QUESTIONNAIRE SCORING KEY

This self-administered questionnaire is designed to provide programs with a set of general guidelines to assist in determining an individual's **suitability for treatment/recovery services in a non-medical facility**. It is intended as a guideline only and should not be substituted for common sense or any other available data which contradicts this questionnaire. When in doubt, always consider the severity of the issue and, above all, the well-being of the client. The potential value of a thorough Health Screening administered by a nurse practitioner or physician should never be underestimated.

The high incidence of illness at time of admission to a program calls for caution and attention to detail. No client can benefit from a program if he or she is too ill to participate fully. Conversely, no program can succeed if its clients are unable to utilize the services offered.

Section 1

A **yes** answer to any of the questions in section 1 indicates the existence of a potentially life threatening condition. You should strongly consider referring the individual to a qualified physician, requesting that they provide you with a medical clearance to participate in a program. Enrollment in the program prior to receiving a medical clearance is at the discretion of the program.

Section 2

A **yes** answer to any of the questions in section 2 indicates the existence of a serious health condition. Although admission into your program may be appropriate, a thorough Health Screening should be scheduled at the time of admission. Continuing participation in the program should be at the discretion of program.

Section 3

A **yes** answer to any of the questions in section 3 does not necessarily indicate the existence of a serious health condition. However, **multiple yes** answers could be cause for concern and indicative of a generally poor health condition. Multiple yes answers in section 3 may warrant a Health Screening. At a minimum information gathered in section 3 should be available to staff in order to better serve the client.

CLIENT HEALTH QUESTIONAIRE

Name:____ Date of Birth: ______________

Date: ____

This brief questionnaire is about your health. It will assist us in determining your ability to participate in our program. This information is confidential.

Section 1

1. Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If yes, please give details.

   No ☐ Yes ☐ Date: ___________ Details:________________________________

2. Have you ever had a stroke? If yes, please give details.

   No ☐ Yes ☐ Date: ___________ Details:________________________________

3. Have you ever had a head injury that resulted in a period of loss of consciousness? If yes, please give details.

   No ☐ Yes ☐ Date: ___________ Details:________________________________

4. Have you ever had any form of seizures, delirium tremens or convulsions? If yes, please give details.

   No ☐ Yes ☐ Date: ___________ Details:________________________________

5. Have you experienced or suffered any chest pains? If yes, please give details.

   No ☐ Yes ☐ Date: ___________ Details:________________________________

Section 2

6. Have you ever had a heart attack or any problem associated with the heart? If yes, please give details.

   No ☐ Yes ☐ Date: ___________ Details:________________________________

7. Do you take any medications for a heart condition? If yes, please give details.

   No ☐ Yes ☐ Date: ___________ Details:________________________________

8. Have you ever had blood clots in the legs or elsewhere that required medical attention? If yes, please give details.

   No ☐ Yes ☐ Date: ___________ Details:________________________________

9. Have you ever had high-blood pressure or hypertension? If yes, please give details.

   No ☐ Yes ☐ Date: ___________ Details:____________________________________

10. Do you have a history of cancer? If yes, please give details.

    No ☐ Yes ☐ Date: ___________ Details:_________________________________

11. Do you have a history of any other illness that may require frequent medical attention? If yes, please give details.

    No ☐ Yes ☐ Date: ___________ Details: ________________________________

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Section 3

12. Do you have any allergies to medications, foods, animals, chemicals, or any other substance. If yes, please give details.

    No ☐ Yes ☐ Date: ___________ Details: ____________________________________

13. Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If yes, please give details.

    No ☐ Yes ☐ Date: ___________ Details: ____________________________________

14. Have you ever been diagnosed with diabetes? If yes, please give details, including insulin, oral medications, or special diet.

    No ☐ Yes ☐ Date: ___________ Details:____________________________________

15. Have you ever been diagnosed with any type of hepatitis or other liver illness? If yes, please give details.

    No ☐ Yes ☐ Date: ___________ Details:____________________________________

16. Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If yes, please give details.

    No ☐ Yes ☐ Date: ___________ Details:____________________________________

17. Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If yes, please give details.

    No ☐ Yes ☐ Date: ___________ Details:____________________________________

18. Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder. If yes, please give details.

    No ☐ Yes ☐ Date: ___________ Details:____

19. Do you have any of the following; arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If yes, please give details, including any ongoing pain or disabilities.

    No ☐ Yes ☐ Date: ___________ Details:____________________________________

20. Please describe any surgeries or hospitalizations due to illness or injury that you have had.

    Date: ____

21. When was the last time you saw a physician? What was the purpose of the visit?

    Date: ____

22. Do you take any prescription medications including psychiatric medications? If yes, please list type(s) and dosage(s).

    No ☐ Yes ☐ Details: ____

23. Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If yes, list the medication(s) and how often you take it.

    No ☐ Yes ☐ Details: ____

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24. Do you take over the counter digestive medications such as Tums or Maalox? If yes, list the medication(s) and how often you take it.

No ☐ Yes ☐ Details: ____

25. Do you wear or need to wear glasses, contact lenses, or hearing aids? If yes, please give details.

No ☐ Yes ☐ Details: ____

26. When was your last dental exam? Date:____________ _ __ _

27. Are you in need of dental care? If yes, please give details.

No ☐ Yes ☐ Details: ____

28. Do you wear or need to wear dentures or other dental appliances that may require dental care? If yes, please give details.

No ☐ Yes ☐ Details: ____

29. Are you pregnant?

No ☐ Yes ☐ Due Date: ____

30. In the past seven days what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

31. In the past year what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

I declare that the above information is true and correct to the best of my knowledge:

Client Signature:___________________________________Today's Date:______________________________

Reviewing Facility/Program Staff Name:

Reviewing Facility/Program Staff Signature:______________________________Date: ____________________