HEALTH SCREENING QUESTIONNAIRE
Contact information

Name: _____________________________________________________________________________
Address: _________________________________ Apt: ____________ City: ____________________
Date of Birth: ____________________ Age: __________ Sex: Male Female
Home Telephone: (___) ______________ Work or Cell Phone: (___) ____________________

Medical History Screening:

Do you have a history of:

☐ Eating Disorder ☐ Cancer (__________) ☐ Colitis
☐ Epilepsy ☐ High Blood Pressure ☐ Rheumatoid Arthritis
☐ Depression ☐ Heart Disease ☐ Lupus
☐ ADHD ☐ Kidney Disease ☐ Hormone Imbalances
☐ Mental Illness (__________) ☐ Thyroid Disease
☐ Diabetes

Have you ever been institutionalized? Y ________ N ________ Approximate Date(s): ______________
Have you had any surgeries (recent or past): __________________ Approximate Date(s): ______________
Do you have any binge eating tendencies/ habits? _______________ If so, how often? _______________

For women only:

Are you Pregnant: __ Yes ___ No Are you Nursing? ___ Yes ___ No For how long? _____________

I, _______________________ affirm all the information on this form to be accurate and true to the best of
my knowledge. I will not hold Dalewood Health Clinics or any of their staff responsible for any of my errors
or omission.

Date: _______________________ Client Signature: _______________________________________

ALL INFORMATION IS HELD IN THE STRICTEST CONFIDENCE. PLEASE COMPLETE THIS HEALTH
SCREENING WITH AS MUCH DETAIL AND ACCURACY AS POSSIBLE AND RETURN IT TO THE
DALEWOOD STAFF MEMBER.