HEALTH QUESTIONAIRE

T. Michael Knack Ph.D.

DATE: ___________________

NAME: __________________________________ DOB: _________________

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

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

How often? ____

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

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

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

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Please list all medications you are currently taking. ___________________

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