Plymouth State UNIVERSITY

**HEALTH SERVICES SCREENING QUESTIONNAIRE**

Name:_____ Nickname:_____ Date of birth:_____
School Address:_____

Cell phone:_____ Messages? Yes ☐ No ☐

Home Address:_____
Home Phone:_____ Messages? Yes ☐ No ☐

Primary Medical Provider:_____ Phone #:_____

Other Medical specialists:_____ Phone#:_____

**CONCERNS:**
Why did you seek evaluation at this time?

What are you concerned about?

How can we best be of help?

**PAST MEDICAL HISTORY:** ***If yes, please explain***
Do you have any on-going medical problems/illnesses? Yes ☐ No ☐ _____
_____
Hospitalizations (medical or psychiatric): Yes ☐ No ☐ _____
Surgeries: Yes ☐ No ☐ _____
Injuries: Yes ☐ No ☐ _____
Hearing Problems: Yes ☐ No ☐ _____
Vision Problems: Yes ☐ No ☐ _____
Allergies: Yes ☐ No ☐ _____
Immunizations up to date? Yes ☐ No ☐ If not, explain_____

**SOCIAL:**
Do you live on campus or off-campus?

Do you live with others?

Who are your support people?

**SUBSTANCE USE:** ***If yes, please explain***

Do you use tobacco/nicotine products? Yes ☐ No ☐

If so, how many carts/pods/cigarettes/cigars do you use and how often?

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Do you drink alcohol? Yes ☐ No ☐

If so, what type, how much, and how often?

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Do you use other drugs (e.g. cannabis, hallucinogens, inhalants, opioids, caffeine)? Yes ☐ No ☐

If so, what, how much, and how often?

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**PSYCHOLOGICAL HISTORY:**

Have you had any evaluations for mood, attention or behavioral problems in the past: Yes ☐ No ☐

If so, when and where?

Has anyone given you a diagnosis in the past? (for example ADHD, depression): Yes ☐ No ☐

If so, what?

Have you had any treatment (including therapy, medications, etc.) for mood, attention or behavioral problems in the past? Yes ☐ No ☐

If so, what and when?

**DEVELOPMENTAL HISTORY:**

Have you ever been diagnosed with a learning disability or a developmental delay?

Did you receive special education or special help when you were in grade or high school, such as a 504 plan or IEP?

**FAMILY HISTORY:**

Has anyone in your family ever experienced any of these conditions?

| Condition: | If so, that person's relationship to you: |
|---|---|
| Learning disability: Yes ☐ No ☐ | _____ |
| ADHD/Attention problems: Yes ☐ No ☐ | _____ |
| Intellectual Impairment: Yes ☐ No ☐ | _____ |
| Depression: Yes ☐ No ☐ | _____ |
| Anxiety: Yes ☐ No ☐ | _____ |
| Manic-Depression/Bipolar: Yes ☐ No ☐ | _____ |
| Drug/Alcohol Abuse: Yes ☐ No ☐ | _____ |
| Special Education: Yes ☐ No ☐ | _____ |

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*Signature:* *Date:*