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Adult History Form

Please provide the following information and answer the questions below. Note: The information you provide here is protected as confidential information.

Please fill out this form completely and bring it to your first session.

Last Name: ________________________________ First Name: ____________________ Middle Initial___

Name You Would Like to Be Called (Nickname): ____

Street Address: ____

City ____ State _____________ Zip _________________

Home Phone: (______) ______________________ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: (______) ______________________ May we leave a message? ☐ Yes ☐ No

E-mail: ____ May we email you? ☐Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact (Nearest relative not living at patient address above):

Name: Address: Relationship: Phone:
____

Primary Care Physician Name: __________________________________ Phone: ______________________

Referred by (if any): ____

Driver's License No. & State _________________________________

Birth Date: ______ /______ /______ Age: ________ Gender: ☐ Male ☐ Female

Relationship Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of years in current relationship: ________________

List children's names, ages, and current grade in school or occupations:
____
____
____

Have you previously received mental health services (psychotherapy, psychiatric services, etc.)?

☐ Yes ☐ No If Yes, previous therapist/practitioner: ____

What made you seek help at this time? ____
____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health? (please check one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing:

____
____

2. Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

3. Please list all current medications, including supplements, and the physician who prescribed them:

____
____

4. Have you ever been hospitalized? ☐ Yes ☐ No If yes, please provide details:

<u>Date</u> <u>Location</u> <u>Reason</u> <u>Outcome</u>

____
____
____

5. Have you ever had a head injury? ☐ Yes ☐ No
When and describe: ____

6. Have you ever had lost consciousness? ☐ Yes ☐ No
When and describe: ____

7. How would you rate your current sleeping habits? (please check one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

____

8. How many times per week do you generally exercise? ___________________________________

What types of exercise do you participate in: ____

9. Please list any difficulties you experience with your appetite or eating patterns:

____

10. Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No
If yes, for approximately how long? ____

11. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No
If yes, when did you begin experiencing this? ____

12. Are you currently experiencing any chronic pain? ☐ Yes ☐ No
If yes, please describe____

13. How many drinks of alcohol do you have in a week? ________

14. Do you use recreational drugs? ☐ Yes ☐ No
If yes, which ones: ____
How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently

15. What significant life changes or stressful events have you experienced recently:
____
____
____

ABUSE/TRAUMA:

Have you ever been physically/sexually/emotionally abused? ☐ Yes ☐ No

Alleged abuser(s): ____

At what age(s): ___________ Have you ever experienced any other severe trauma? ☐ Yes ☐ No

If yes, explain: ____

Have you been a victim of domestic violence (emotional, physical or sexual)? ☐ Yes ☐ No If yes,

explain: ____
____

YOUR FAMILY:

PARENT

Name: ______________________________ Age: ______________

Occupation: ____________________ Health: ______________________

If deceased, cause of death: ______________________________________

PARENT

Name: ______________________________ Age: ______________

Occupation: ____________________ Health: ______________________

If deceased, cause of death: ______________________________________

Describe your parents' personalities and their attitudes toward you (past and present): ______________
____

Were you disciplined as a child? If so, how? ____

____

Give an impression of the atmosphere in the home where you grew up. Mention whether parents were compatible with each other and with children: ____

____

Siblings names/Ages/Occupations:

____

____

____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Family History:	Check one:	Family Member Relationship:
Alcohol/Substance Abuse	☐ Yes ☐ No	__________________________
Anxiety	☐ Yes ☐ No	__________________________
Depression	☐ Yes ☐ No	__________________________
Domestic Violence	☐ Yes ☐ No	__________________________
Eating Disorders	☐ Yes ☐ No	__________________________
Obsessive Compulsive Behavior	☐ Yes ☐ No	__________________________
Psychiatric Hospitalizations	☐ Yes ☐ No	__________________________
Schizophrenia	☐ Yes ☐ No	__________________________
Suicide Attempts	☐ Yes ☐ No	__________________________

Has someone in your family or your spouse/partner ever been arrested? ☐ Yes ☐ No

Name	Relationship to You	What Charges	Outcome

CURRENT MARRIAGE/RELATIONSHIP:

How long have you known your current spouse/partner? ____

Name of spouse/partner: ____

Your spouse/partner's age: ____________ Number of years in relationship or marriage: ________________

In what areas are you compatible? ____

In what areas are you not compatible? ____

Your spouse/partner's occupation: ____

Does your spouse/partner have a history of: Domestic violence? □ Yes □ No

Substance abuse? □ Yes □ No

Mental health treatment? □ Yes □ No

How do you get along with your in-laws/partner's family? ____

RELATIONSHIP HISTORY:	**Self**	**Partner**
Number of significant relationships:	______________________	______________________
Date of most recent:	______________________	______________________
Age at time:	1st ________ 2nd ________	1st ________ 2nd ________
Date of recent separation:	______________________	______________________
Date of divorce/separation:	1st ________ 2nd ________	1st ________ 2nd ________
Names of children from previous relationship:	______________________	______________________
Former spouse/partner name(s):	1st ______________________ 2nd ______________________	1st ______________________ 2nd ______________________

YOUR EDUCATION:

Highest Grade completed: ______________ College degree(s): ________________________________

College attended: ____________________________________

Any behavioral problems in school: ____

Any learning or emotional disabilities identified: ____

Did you serve in the military? □ Yes □ No How long? _________ Discharge status: __________________

YOUR OCCUPATION:

Are you currently employed? ☐ Yes ☐ No If yes, what is your occupation: ______________________________

Are you receiving disability? ☐ Yes ☐ No Have you ever been terminated from employment? ☐ Yes ☐ No

In what ways are you satisfied or dissatisfied at work? ______________________________

____

YOUR SOCIAL HISTORY:

Are you satisfied with the number of friendships you have? ______________________________

Are you satisfied with the quality of friendships you have? ______________________________

Interests, hobbies, talents: ______________________________

____

Clubs/Groups/Church: ______________________________

LEGAL HISTORY:

Have you ever been arrested? ☐ Yes ☐ No If yes, please list specific charges and outcome.

Date	Charge	County, State	Outcome

Are you or your immediate family currently involved in any legal proceeding(s)? (i.e.: divorce, criminal, civil related issue(s)? ______________________________

____

If yes - name and contact information of attorney: ______________________________

____

Have you or your current spouse/partner ever been reported to the Department of Children and Families? ☐ Yes ☐ No If yes, explain: ______________________________

____

______________________________ Signature

______________________________ Date Completed