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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): _____

SSN: _____ 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: _____

Children's names/Ages/Occupations or current grade in school:

_____

_____

_____

Have you previously received any type of 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 and the physician who prescribed them:

_____

_____

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

Date	Location	Reason	Outcome

_____

_____

_____

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 (please circle)? ☐ 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:

FATHER

Name: _____ Age: _____

Occupation: _____ Health: _____

If deceased, cause of death: _____

MOTHER

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? _____

MARRIAGE HISTORY:	**Self**	**Spouse**
Number of marriages:	_____	_____
Date of most recent marriage:	_____	_____
Age at time of marriage(s):	1st _____ 2nd _____	1st _____ 2nd _____
Date of recent separation:	_____	_____
Date of divorce(s):	1st _____ 2nd _____	1st _____ 2nd _____
Names of children from previous relationship:	_____	_____
Former spouse name(s):	1st _____ 2nd _____	1st _____ 2nd _____

YOUR EDUCATION:

Highest Grade completed: _____ College degree(s): _____

College attended: _____ Grade point average: _____

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 currently receiving disability? ☐ Yes ☐ No

Have you ever been terminated from employment? ☐ Yes ☐ No

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