Name:_____ Date_____

MEDICAL AND PERSONAL HISTORY (ADULT)

Thank you for taking the time to answer these questions. Your completing this form makes it possible for us to have more time to talk during the initial session.

Please indicate if you have or have had any of these symptoms now or in the last few weeks:

___ Fatigue or low energy
___ Depressed mood, feeling down or blue most of the time
___ Not enjoying things you usually enjoy
___ Feeling slowed down or very sluggish
___ Feeling nervous, agitated, or antsy
___ Feeling worthless or guilty
___ Can't concentrate or pay attention
___ Can't make decisions
___ Poor self-esteem
___ Irritable, cranky, out-of-sorts
___ Crying spells
___ Not interested in sex or other sexual issues
___ Drinking more alcohol than usual
___ Feeling anxious most of the day
___ Frequent thoughts of death or dying
___ Excessive worrying
___ Feeling like life is not worth living
___ Panic episodes (e.g., palpitations, sweating, shaking, shortness of breath, nausea or
dizziness, feeling that the world is coming to an end)
___ Don't want to leave the house or go out in public
___ Increase in aches and pains (headaches, stomach distress, etc.)
___ Repetitive thoughts that you can't get out of your mind

Sleep disturbance:

___ Can't get to sleep
___ Can't stay asleep
___ Waking up early in the morning and can't get back to sleep
___ Sleeping too much
___ Bad dreams
___Excessive snoring
___Persistent daytime fatigue

Appetite/eating changes:

___ Decreased appetite
___ Increased appetite
___ Frequent nausea or gastrointestinal distress
___ Weight change in last month: _____

___ Other troublesome symptoms. Please specify: _____
_____
_____

Please list any health problems that you have (for example, allergies, migraines, diabetes, arthritis, high blood pressure, etc.):

_____
_____
_____
_____

Please list any medications that you take (include prescription medication and over-the-counter medication such as aspirin or Pepcid as well as any herbal or homeopathic preparations):

Medication	Dosage	When started?	Dr. who prescribes

Have you ever had any allergic reactions to any medicinal agents? Yes No

If yes, please explain:

When was your last physical exam and by whom was it conducted? _____

Does anyone in your family (parents, grandparents, siblings) have a history of any of the following? Please specify who had the problem.

Problem	Who?
___ Depression	_____
___ Bipolar disorder ("manic-depressive")	_____
___ Alcoholism	_____
___ Other drug use	_____
___ Schizophrenia	_____
___ Attention Deficit/Hyperactivity	_____
___ Severe obesity	_____
___ Anorexia/bulimia/other eating disorder	_____
___ Attempted suicide (tried but lived)	_____

___ Completed suicide (died as result) _____
___ Other psychiatric disorder _____

Do you use caffeine? Yes No How many drinks per day? _____
Do you use alcohol? Yes No How many drinks per week? _____
Do you smoke cigarettes? Yes No How many packs per day? _____
Do you use other tobacco products? Yes No How often?_____

Have you ever had any psychological counseling/therapy/evaluation in the past? Yes No
Please indicate when and for what purpose: _____
_____
_____
_____
Did you find this helpful? _____
_____

PERSONAL HISTORY:

Mother's occupation: _____
Mother's current age or date of death: _____
Father's occupation: _____
Father's current age or date of death: _____
Siblings:
Number of older sisters _____
Number of older brothers _____
Number of younger sisters _____
Number of younger brothers _____
Number of step/adoptive/foster siblings _____
Who reared you if you were not reared by your biological or adoptive parents? _____
_____

You highest level of education: _____
Your current occupation: _____
Religious preference, if any: _____

Are you married or partnered? Yes No
Spouse/partner's first name and occupation: _____
First names and ages of children: _____
_____

EMERGENCY CONTACT: In the event of an emergency, whom should we contact?
Name:
_____
Address: _____
Relationship to you: _____
Phone numbers: Home _____ Business _____
Cell: _____