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Check one: rev 1-7-20

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ADULT HEALTH HISTORY FORM

Today's date: _____

Name: _____Age: ____ Date of birth: _____

If other than client, name of person completing this form and relationship to client:
_____

What is the reason for the visit today? _____
_____

Who is requesting or recommending these services? (circle all that apply)

Therapist **Physician** **Psychiatrist**

Attorney **DFCS** **Court** **Other**? _____

CHECK THE FOLLOWING THAT APPLY:

__ Depression	__ Anxiety	__ Self-harming behavior
__ Mood swings	__ Low motivation	__ Low self-esteem
__ Suicidal ideation	__ Hallucinations	__ Bizarre or strange behavior
__ Hyperactivity	__ Difficulty focusing	__ Difficulty concentrating
__ Aggression	__ Anger	__ Poor social skills
__ Poor eye contact	__ Poor memory	__ Organization problems
__ Eating disorder symptoms	__ Low frustration tolerance	

Are there any additional problems or concerns? If yes, briefly describe: _____

MEDICAL HISTORY

Any delays with developmental milestones (talking, walking, etc.)?
YES **NO** If yes, please explain: _____
_____

Date of last visit to a primary care physician or other medical doctor? _____
Any concerns at that time? **YES** **NO**
If yes, please explain): _____

Hearing or vision problems? **YES** **NO**
If yes, are they corrected (glasses, contacts, hearing aids)? _____

Have you ever been hospitalized for medical reasons (not psychiatric) ? **YES** **NO**
If yes, reason and approximate date(s): _____
_____

Have you ever had surgery? **YES** **NO**
If yes, please describe: _____

Do you have any chronic illness (diabetes; asthma, etc.)? **YES** **NO**
If yes, please briefly _____
_____

Do you have any medication, food, or other allergies? **YES** **NO**
If yes, please briefly describe)? _____

Do you ***currently*** take any prescription medications (non-psychiatric)? **YES** **NO**
If yes, medication names: _____

Have you ever had any head injuries? **YES** **NO**
If yes, briefly describe: _____

Have you ever had any other major injuries? **YES** **NO**
If yes, briefly describe _____

Do you have any appetite problems or problematic weight gain or weight loss? **YES** **NO**
If yes, briefly describe: _____

Do you have any problems with your sleep? **YES** **NO**
If yes, briefly describe: _____

FAMILY HISTORY

Parents' names: _____

Mother, living or deceased? _____ Father, living or deceased? _____

Names and ages of your siblings: _____

_____

Who currently lives in your home? _____

_____

Check any family current or recent stressors:
(described further in the comments section below as needed)

___ Separation or divorce
___ New job
___ Death of a family member
___ Death of a pet
___ Substance abuse problem of a family member
___ Other _____
____ Move to a new home
____ Loss of a job
____ Birth of a child
____ Serious illness of a family member

Recreational activities? _____

Relationship status? (circle one) **Married partnered single divorced widowed**

EDUCATIONAL HISTORY

Highest grade or educational level achieved: _____

Did you repeat any grades? (if yes, which one?) _____

Did you receive any special education services? **YES NO**
If yes, for what reason? (circle all that apply) **behavioral emotional academic difficulty**

Any major behavioral problems in school, or major school discipline (such as suspensions, expulsions) ? **YES NO**
If yes, briefly describe: _____

MENTAL HEALTH HISTORY

Have you ever received a mental health diagnosis in the past? **YES** **NO**
If yes, what diagnosis? _____

Have you ever seen a psychiatrist for psychiatric medication? **YES** **NO**
If yes: Name of psychiatrist? _____ When? _____

Are your ***CURRENTLY*** taking psychiatric medications? **YES** **NO**
If yes, name(s) of medication(s): _____
When was your last appointment? _____
How long have you received treatment by a psychiatrist (months, years)? _____

Have you taken any other psychiatric medication in the past? **YES** **NO**
If yes, names of medications and dosages (if known): _____
_____
Have you ever had a psychological evaluation? **YES** **NO**
If yes, when and what was the diagnosis? _____

Are your ***CURRENTLY*** receiving therapy or counselling for emotional or behavioral problems?

(circle all that apply)	Provider or Agency	Date Started	Frequency	For what issues?
Individual				
Group				
Family				
Other				

Have you received therapy or counseling in the ***PAST*** for emotional or behavioral problems?

(circle all that apply)	Provider or Agency	Date Started	Date Stopped	Why did the therapy stop?
Individual				
Group				
Family				
Other				

Have you ever been admitted to a psychiatric hospital? **YES** **NO**
If yes, please list date(s) and name(s) of hospitals: _____
_____

Have you ever had suicidal thoughts or made suicidal threats? **YES** **NO**
If yes, briefly describe: _____
_____

Have you made any suicide attempts? **YES** **NO**
If yes, briefly describe: _____
_____

Have your ever been abused or neglected? **YES** **NO**
If yes, circle those that apply and briefly describe:

(circle all that apply)	Briefly describe
Physical	
Verbal / Emotional	
Sexual	
Neglect	

Do you have any family history of mental health problems? **YES** **NO**
If yes, briefly describe: _____

How were you disciplined as a child? _____
Do you believe it was abusive or excessive? **YES** **NO**
If yes, briefly describe: _____

Have you ever had anger management issues, either now or in the past? **YES** **NO**
If yes, briefly describe: _____