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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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self-harming behavior |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Low motivation | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Suicidal ideation | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Bizarre or strange behavior |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Difficulty focusing | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Anger | <input type="checkbox"/> Poor social skills |
| <input type="checkbox"/> Poor eye contact | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Organization problems |
| <input type="checkbox"/> Eating disorder symptoms | <input type="checkbox"/> 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)

- | | |
|---|---|
| <input type="checkbox"/> Separation or divorce | <input type="checkbox"/> Move to a new home |
| <input type="checkbox"/> New job | <input type="checkbox"/> Loss of a job |
| <input type="checkbox"/> Death of a family member | <input type="checkbox"/> Birth of a child |
| <input type="checkbox"/> Death of a pet | <input type="checkbox"/> Serious illness of a family member |
| <input type="checkbox"/> Substance abuse problem of a family member | |
| <input type="checkbox"/> Other _____ | |

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 you **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 you **CURRENTLY** receiving therapy or counselling for emotional or behavioral problems?

<i>(circle all that apply)</i>	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?

<i>(circle all that apply)</i>	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 you ever been abused or neglected? **YES** **NO**
 If yes, circle those that apply and briefly describe:

<i>(circle all that apply)</i>	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: _____