# Adult History Form

Date _____

Name _____ DOB _____ Age _____

Referred by? _____

## CURRENT CONCERNS

Description: Please list/describe your problems starting with the most serious:

Onset: When did the above problem start? Were there major stresses then?

Recent stressful life events (in last 2 years): (Circle all and explain.)

| | | | | |
|---|---|---|---|---|
| marriage/engagement | separation/divorce | breakup of important relationship | death of close family/friend | personal |
| injury/illness | changes in school/work | changes in residence | financial/legal difficulties | |

Functioning: How has this affected your work, school, other activities?

Past Psychiatric Problems: Have you been evaluated or treated for other psychiatric problems? (*Medication Summary*)

Treatment: What kinds of things have you tried in order to take care of the problems?



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Other Treating Clinicians:

Current Medications:

## FAMILY INFORMATION

| | Age | Degree Grade | Comments |
|---|---|---|---|
| Father:_____<br>Biological ( ) Step ( ) Foster ( ) Adoptive ( )<br>Occupation: | | | |
| Mother:_____<br>Biological ( ) Step ( ) Foster ( ) Adoptive ( )<br>Occupation: | | | |
| Children: (In Chronological Order) | | | |
| Others in Home | | | |

## MEDICAL INFORMATION

A. Present Medical Health:

1. How is your general health? Poor Fair Good Excellent
2. Do you currently have or have you in the past had a problem with:

| | | | |
|---|---|---|---|
| Head? | YES | NO | PAST |
| Eyes? | YES | NO | PAST |
| Ears? | YES | NO | PAST |
| Nose? | YES | NO | PAST |
| Throat? | YES | NO | PAST |
| Respiratory System? | YES | NO | PAST |
| Heart and Blood Vessels? | YES | NO | PAST |
| Digestive Tract? | YES | NO | PAST |
| Genito-Urinary System? | YES | NO | PAST |
| Muscles? | YES | NO | PAST |
| Bones? | YES | NO | PAST |
| Hormone-System? | YES | NO | PAST |



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3. Do you currently have any of the following?

| | | | |
|---|---|---|---|
| High blood presssure? | YES | NO | NOT SURE |
| Heart Disease? | YES | NO | NOT SURE |
| Chest Pain? | YES | NO | NOT SURE |
| Asthma? | YES | NO | NOT SURE |
| Ephysema/COPD? | YES | NO | NOT SURE |
| Recurrent bronchitis? | YES | NO | NOT SURE |
| Pancreatitis? | YES | NO | NOT SURE |
| Hepatitis? | YES | NO | NOT SURE |
| Diabetes? | YES | NO | NOT SURE |
| Blood transfusions? | YES | NO | NOT SURE |
| Glaucoma? | YES | NO | NOT SURE |
| High cholesterol/lipids? | YES | NO | NOT SURE |
| Lyme Disease? | YES | NO | NOT SURE |

## B. Past Medical History

1. Have you ever been hospitalized for medical reasons? (When? Why?) YES NO NOT SURE

_____

2. Had any serious illness/injuries? No/Yes_____
3. Had any operations? No/Yes_____
4. Have you ever had any of the following?

| | | | |
|---|---|---|---|
| Severe Headaches? | YES | NO | NOT SURE |
| Seizures? | YES | NO | |
| With High fever? | YES | NO | NOT SURE |
| Medications for seizures? | YES | NO | NOT SURE |
| Loss of consciousness (blackout)? | YES | NO | NOT SURE |
| Hit in the head? | YES | NO | NOT SURE |
| Dizziness? | YES | NO | NOT SURE |
| Double vision? | YES | ND | NOT SURE |
| Lack of coordination? | YES | NO | NOT SURE |
| Memory problems? | YES | NO | NOT SURE |
| History of encephalitis? | YES | NO | NOT SURE |
| Meningitis? | YES | NO | NOT SURE |
| Fainting spells? | YES | NO | NOT SURE |
| Tremor? | YES | NO | NOT SURE |
| Momentary lapses of consciousness? | YES | NO | NOT SURE |
| Trance-like episodes? | YES | NO | NOT SURE |
| Trouble walking? | YES | NO | NOT SURE |
| Cardiac/heart-insert after head or nerve problem? | YES | NO | NOT SURE |
| Sleep disturbance? | YES | NO | NOT SURE |
| snore | YES | NO | NOT SURE |
| jerk your arms/legs while asleep | YES | NO | NOT SURE |
| awake gasping for breath | YES | NO | NOT SURE |
| have creeping or crawling leg sensations | YES | NO | NOT SURE |
| fall asleep suddenly during the day | YES | NO | NOT SURE |
| walk/talk in your sleep | YES | NO | NOT SURE |

# PAST PSYCHIATRIC HISTORY

(Additional space at end of form to elaborate)

Dates/Comments

| | | | |
|---|---|---|---|
| 1. Have you ever been a psychiatric inpatient? | NO | YES | _____ |
| 2. Have you ever had problems with: | | | |
| depressed mood? | NO | YES | _____ |
| anger? | NO | YES | _____ |



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| | | | |
|---|---|---|---|
| irritable mood? | NO | YES | _____ |
| an unstable mood? | NO | YES | _____ |
| seasonal mood changes? | NO | YES | _____ |
| 3. Have you ever had: | | | |
| suicidal thoughts | NO | YES | _____ |
| attempted suicide? | NO | YES | _____ |
| hurt yourself in other ways? (i.e cut,etc) | NO | YES | _____ |
| 4. Have you ever had sleep disturbances such as: | | | |
| problems falling asleep? | NO | YES | _____ |
| problems staying asleep? | NO | YES | _____ |
| problems waking too early in morning? | NO | YES | _____ |
| sleeping too much? | NO | YES | _____ |
| lack of need for sleep? | NO | YES | _____ |
| 5. Do you ever have: | | | |
| periods of excessive energy? | NO | YES | _____ |
| thoughts so fast that you cannot keep up? | NO | YES | _____ |
| diminished need for sleep? | NO | YES | _____ |
| spending sprees beyond your means? | NO | YES | _____ |
| engaged in very risky/dangerous activities? | NO | YES | _____ |
| people comment that your mood is too good? | NO | YES | _____ |
| people tell you that you speak too rapidly? | NO | YES | _____ |
| 6. Have you ever: | | | |
| seen things disappear, change shape, color or position? | NO | YES | _____ |
| experienced unusual smells without anything being there? | NO | YES | _____ |
| had feelings of being touched without anyone/thing actually touching you? | NO | YES | _____ |
| had a sense of detachment/unreality? | NO | YES | _____ |
| had a sense of being followed when no one is there? | NO | YES | _____ |
| had a sense that TV/radio is talking or sending messages to you? | NO | YES | _____ |
| 7. Have you ever had the experience of: | | | Dates/Comments |
| finding yourself in a place and having no idea how you got there? | NO | YES | _____ |
| time gone by without any memory of what has happened during that time? | NO | YES | _____ |
| having no memory for some important events in your life (for example, a graduation, wedding, death) | NO | YES | _____ |



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8. Do you worry excessively? NO YES _____

What do worry about?_____

10. Have you ever had a panic attack? NO YES _____

11. Do you startle (jump) easily? NO YES _____

12. Do you have repeating nightmares? NO YES _____

13. Do you ever have:

repetitive, unwanted thoughts/images? NO YES _____

irresistible urges to check or count, clean, touch or say things repeatedly? NO YES _____

spasms, twitches or tics? NO YES _____

14. While in school, did you ever:

have trouble sitting still in class? NO YES _____

have trouble concentrating? NO YES _____

have anxiety about going to school? NO YES _____

get left back or expelled? NO YES _____

run away from home? NO YES _____

13. Have you ever:

binged on food uncontrollably? NO YES _____

forced yourself to vomit ? NO YES _____

used laxatives, water pills, diet pills? NO YES _____

used enemas/ipecac to lose weight? NO YES _____

lost so much weight you stopped having your menstrual period? NO YES _____

been told you are bulemic or anorexic? NO YES _____

been very preoccupied with your weight? NO YES _____

15. Have you ever experienced personal violence? NO YES _____

16. Have you ever been physically abused? NO YES _____

17. Have you ever been sexually abused? NO YES _____

18. Have you ever been verbally abused? NO YES _____

19. Have you ever

been concerned about your alcohol use? NO YES _____

had a problem with alcohol? NO YES _____

had a DUI? NO YES _____

been in treatment for alcohol? NO YES _____

What kind?_____

20. Have you ever had a problem with drugs(illegal)? NO YES _____

What?_____

been in treatment for drugs(illegal/street)? NO YES _____

What kind?_____



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## FAMILY HISTORY

(Additional space at end of form to elaborate)

HAS ANYONE IN THE PATIENT'S FAMILY HAD

| | | | | |
|---|---|---|---|---|
| "Nervous breakdown"? | YES | NO | NOT SURE | WHO?_____ |
| Psychiatric hospitalization? | YES | NO | NOT SURE | WHO?_____ |
| Depression? | YES | NO | NOT SURE | WHO?_____ |
| Manic-depressive/bipolar disorder | YES | NO | NOT SURE | WHO?_____ |
| Suicide? | YES | NO | NOT SURE | WHO?_____ |
| Bipolar disorder? | YES | NO | NOT SURE | WHO?_____ |
| Alcoholism? | YES | NO | NOT SURE | WHO?_____ |
| Drug abuse? | YES | NO | NOT SURE | WHO?_____ |
| Schizophrenia? | YES | NO | NOT SURE | WHO?_____ |
| Obsessive-compulsive disorder? | YES | NO | NOT SURE | WHO?_____ |
| Panic attacks? | YES | NO | NOT SURE | WHO?_____ |
| Anxiety Disorder | YES | NO | NOT SURE | WHO?_____ |
| Tourette's disease/tics? | YES | NO | NOT SURE | WHO?_____ |
| Anorexia or bulimia? | YES | NO | NOT SURE | WHO?_____ |
| ADD/ADHD | YES | NO | NOT SURE | WHO?_____ |
| School problems? | YES | NO | NOT SURE | WHO?_____ |
| Learning disabilities? | YES | NO | NOT SURE | WHO?_____ |
| Mental retardation? | YES | NO | NOT SURE | WHO?_____ |
| Autism? | YES | NO | NOT SURE | WHO?_____ |
| Asperger's Syndrome? | YES | NO | NOT SURE | WHO?_____ |
| Epilepsy? | YES | NO | NOT SURE | WHO?_____ |
| Alzheimer's disease? | YES | NO | NOT SURE | WHO?_____ |
| Wilson's disease? | YES | NO | NOT SURE | WHO?_____ |
| Parkinson's disease? | YES | NO | NOT SURE | WHO?_____ |
| Heart attack before the age of 50 | YES | NO | NOT SURE | WHO?_____ |
| Unexplained sudden death. | YES | NO | NOT SURE | WHO?_____ |
| Arrhythmia. | YES | NO | NOT SURE | WHO?_____ |
| Congenital cardiac issues | YES | NO | NOT SURE | WHO?_____ |
| Structural Cardiac issues | YES | NO | NOT SURE | WHO?_____ |
| Syncope/fainting | YES | NO | NOT SURE | WHO?_____ |

## OTHER COMMENTS

_____

_____

_____

_____

_____

_____

_____

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