# Adult History Form

**Form completion date: ___________**

***Please fill out this form to the best of your knowledge. If some questions are not applicable, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.***

Name:_______________________________________________ Date of Birth: ________________________

Reason for seeking treatment:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

How long has this problem existed? (please check one):

☐ 1-3 mos. ☐ 6-12 mos. ☐ 1-2 yrs. ☐ 2-5 yrs. ☐ 10+ yrs.

Prior Therapy? ☐ Yes ☐ No If yes, what was the duration? ☐ Brief ☐ Long Term

Type of environment? (please check one) ☐ Periodic Sessions ☐ Day Treatment ☐ Inpatient

Was it: ☐ Helpful ☐ Not Helpful ☐ Not sure

Current Marital Status: ______________________ Current Primary Physician: _________________________

Occupation: ______________________________ Current Employment: _____________________________

High School graduate? (please check one) ☐ Yes ☐ No ☐ GED

College Graduate ☐ Yes ☐ No

| Degree (S) | # of credits | Field of Study |
| --- | --- | --- |
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Occupational Training (please explain):

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_______________________________________________________________________________

_______________________________________________________________________________

Any Military Service?

_______________________________________________________________________________

_______________________________________________________________________________

Religious Affiliation?

_______________________________________________________________________________

Recreation *(list some usual activities)*

________________________ ________________________

________________________ ________________________

________________________ ________________________

________________________ ________________________

Have you ever been married? (please check one) ☐ Yes ☐ No

| If yes, provide here. | How long did marriage last? |
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**Who is in your household?**

| Name | Age | Relationship |
|---|---|---|
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Do you have children who do not live with you? (please check one) ☐Yes ☐No

*If yes, please provide name(s) and age(s):*

| Name | Age |
|---|---|
| | |
| | |
| | |
| | |
| | |

Have there been deaths in your family or among your friends? ☐ Yes ☐ No

If yes: Who: ___________________________ When: ___________________________________

___________________________ ___________________________________

___________________________ ___________________________________

Have you moved recently? ☐ Yes ☐ No

If yes when: ______________________________

Have you moved often? (If yes, please explain) ☐ Yes ☐ No

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

Do you plan a move soon? (If yes, please explain): ☐ Yes ☐ No

____________________________________________________________________________________________________

____________________________________________________________________________________________________

**Work history for the past 10 years**

| Employer | Job Title | Start Date | End Date | Reason for Leaving |
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**Family of Origin**

*Please provide data on your mother, father, siblings, and any step or half-family members.*

| Name & Relationship | Age | Health Status | Occupation | Where they reside | Frequency of Contact |
|---|---|---|---|---|---|
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Have you ever separated from family members for a prolonged period? ☐ Yes ☐ No

Where there any separations from your family or either parent when you were a child (i.e. mother hospitalized for 3 weeks when you were 5, etc.)? ☐ Yes ☐ No

If yes, please explain:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Is there any history of mental, emotional, or psychiatric problems in your family? ☐ Yes ☐ No

If yes, please explain:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Health History**

*List any medications taken*

| Medication Name | Dosage | Directions | Check if presently taking | Start date – End date | Reason for discontinuing |
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*Hospitalizations*

| Date | Medical or Psychiatric | Purpose | Outcome |
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*Please provide a history of each pregnancy (if applicable) (i.e. to term, miscarriage, abortion,)*

| Date | Outcome |
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Please list any chronic health conditions (i.e. asthma, high blood pressure, etc.)

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_______________________________________________________________________________

_______________________________________________________________________________

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Please list any serious accidents or illnesses for which did not require hospitalization.

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_______________________________________________________________________________

_______________________________________________________________________________

What is your current general state of health?

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_______________________________________________________________________________

_______________________________________________________________________________

**Symptoms and Behaviors Checklist**

*Check the box the best describes the symptom*

| Symptom | None | Low | Medium | High | Extreme |
|---|---|---|---|---|---|
| Depression | | | | | |
| Tearfulness | | | | | |
| Feeling lonely | | | | | |
| Feelings Sad | | | | | |
| Withdrawn | | | | | |
| Spending more time alone | | | | | |
| Moody | | | | | |
| Avoiding Friends | | | | | |
| Concerned about injury | | | | | |
| Eating more | | | | | |
| Eating less | | | | | |
| Weight change | | | | | |
| More exercise | | | | | |
| Less exercise | | | | | |
| Decreased interest in sex | | | | | |
| Decreased interest in usual activities | | | | | |
| Tired | | | | | |
| Sleeping more | | | | | |
| Sleeping less | | | | | |
| Walking during the night | | | | | |
| Waking early in the morning | | | | | |
| Sleep walking | | | | | |
| Nightmares/bad dreams | | | | | |
| Headaches | | | | | |

| Symptom | None | Low | Medium | High | Extreme |
|---|---|---|---|---|---|
| Careless about dress/hygiene | | | | | |
| Having trouble concentrating | | | | | |
| Confused | | | | | |
| Distractible | | | | | |
| Impulsive | | | | | |
| Disorganized | | | | | |
| Hearing things other don't hear | | | | | |
| Seeing things others don't see | | | | | |
| Trouble following directions | | | | | |
| Perfectionistic | | | | | |
| Anxious | | | | | |
| Worrying | | | | | |
| Feeling panicky | | | | | |
| Obsessive/ritualistic behaviors | | | | | |
| Critical of others | | | | | |
| Have few friends | | | | | |
| Low self esteem | | | | | |
| Disappointed in appearance | | | | | |
| Disappointed in achievements | | | | | |
| Disappointed in social life | | | | | |
| Legal problems | | | | | |
| Problems at work | | | | | |
| Problems in daily life | | | | | |
| Arguing | | | | | |
| Defiant | | | | | |
| Destroying/damaging property | | | | | |
| Irritable | | | | | |
| Angry | | | | | |
| Easily frustrated | | | | | |
| Giving away belongings | | | | | |
| Threats to one-self | | | | | |
| Wishes to be dead | | | | | |
| Suicidal thoughts | | | | | |
| Suicidal intent | | | | | |
| Homicidal thoughts | | | | | |