

**CHILD AND FAMILY COUNSELING CENTER
PATIENT HISTORY FORM
ADULT**

IDENTIFYING INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE FORM COMPLETED: _____

REASONS FOR SEEKING TREATMENT: _____

DURATION OF PROBLEM: 1-3 mos. 6-12 mos. 1-2 yrs. 2-5 yrs. 5-10 yrs. 10+yrs.

PRIOR THERAPY? YES NO BRIEF LONG TERM REPEATED DAYTX. INPATIENT
 HELPFUL UNHELPFUL NOT SURE

NAMES OF PREVIOUS THERAPISTS (Include phone numbers if you know them): _____

NAMES OF PREVIOUS PSYCHIATRISTS (Include phone numbers if you know them): _____

FAMILY DATA

CURRENT MARITAL STATUS: NEVER MARRIED MARRIED SEPARATED DIVORCED
 IN A COMMITTED RELATIONSHIP REMARRIED WIDOWED

MARITAL HISTORY

_____ DATES MARRIED _____ SPOUSE'S NAME

1. _____
(continued on next page)

FAMILY DATA (continued)

DATES MARRIED

SPOUSE'S NAME

- 2. _____
- 3. _____
- 4. _____
- 5. _____

IF NOT REMARRIED:

DO YOU HAVE A SIGNIFICANT OTHER? YES NO
IF SO, FOR HOW LONG? _____

WHO LIVES IN YOUR HOME?

ADULTS:

<i>NAME</i>	<i>AGE</i>	<i>RELATIONSHIP</i>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

CHILDREN IN THE HOME AND AGES

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

YOUR OCCUPATION: _____

HOW LONG HAVE YOU BEEN IN YOUR CURRENT JOB? _____

ARE YOU A HIGH SCHOOL GRADUATE? YES NO GED

ARE YOU A COLLEGE GRADUATE? YES NO DEGREE EARNED

FIELD OF STUDY: _____

FAMILY DATA (continued)

HISTORY OF MILITARY SERVICE? YES NO

RELIGIOUS AFFILIATION?: YES NO IF YES, WHICH? _____

DO YOU HAVE CLOSE FRIENDS? NO YES

IF YES, HOW OFTEN ARE YOU IN TOUCH WITH THEM? _____

SUBSTANCE USE/ABUSE

DO YOU USE ALCOHOL? NO YES

IF YES, PLEASE NOTE FREQUENCY AND AMOUNT OF USE (e.g. 3 times weekly, 4-6 beers):

DO YOU USE TOBACCO OR SMOKE CIGARETTES? NO YES

IF YES, HOW MUCH DO YOU SMOKE PER DAY? _____

DO YOU USE DRUGS SUCH AS MARIJUANA OR OTHER DRUGS? NO YES

IF YES, PLEASE LIST DRUGS AND THE FREQUENCY OF USE.

LEGAL HISTORY

ANY HISTORY OF LEGAL PROBLEMS (e.g. arrests or incarceration)? NO YES

IF YES, PLEASE DESCRIBE BRIEFLY: _____

ARE YOU ON PROBATION? NO YES

DO YOU HAVE A COURT DATE COMING UP? NO YES

IF YES, WHAT FOR? _____

FAMILY PSYCHIATRIC AND SUBSTANCE ABUSE HISTORY

IS THERE ANY HISTORY OF VIOLENCE IN THE FAMILY? NO YES

IS THERE ANY HISTORY OF SUICIDE IN THE FAMILY? NO YES

IS THERE ANY HISTORY OF ALCOHOL OR DRUG PROBLEMS IN THE FAMILY? NO YES

IS THERE ANY HISTORY OF PSYCHIATRIC PROBLEMS IN THE FAMILY, E.G. DEPRESSION, ANXIETY, BIPOLAR DISORDER, SCHIZOPHRENIA, ADHD, ETC.? NO YES

IF YES, DESCRIBE:

HAVE THERE BEEN ANY TRAUMATIC EVENTS IN YOUR LIFE? NO YES

IF YES, EXPLAIN:

MEDICAL/HEALTH HISTORY

NAME OF PRIMARY CARE PHYSICIAN: _____

ADDRESS/PHONE: _____

DATE OF LAST PHYSICAL? _____

RIGHT OR LEFT HANDED? RIGHT LEFT

ANY PHYSICAL OR INTELLECTUAL HANDICAPS? YES NO

IF YES, DESCRIBE:

ANY CHRONIC HEALTH CONDITIONS, SUCH AS ASTHMA, HIGH BLOOD PRESSURE, HEART PROBLEMS, ETC? YES NO

IF YES, LIST:

MEDICAL/HEALTH HISTORY (continued)

ANY REGULAR MEDICATIONS? YES NO

LIST ANY MEDICATIONS AND DOSAGES IF KNOWN:

DO YOU TAKE ANY VITAMINS OR OTHER SUPPLEMENTS? YES NO
IF YES, WHICH ONES?

HAVE YOU EVER BEEN HOSPITALIZED FOR PHYSICAL OR EMOTIONAL PROBLEMS? NO YES
IF YES, BRIEFLY DESCRIBE WHEN AND WHY:

ANY HISTORY OF ALLERGIES, INCLUDING ALLERGIES TO MEDICATIONS: NO YES
IF YES, DESCRIBE:

HAVE YOU EVER HAD A SERIOUS MEDICAL PROBLEM? NO YES (explain)
IF YES, EXPLAIN

ANY HISTORY OF HEAD INJURIES, LOSS OF CONSCIOUSNESS, OR BLOWS TO THE HEAD? NO YES
IF YES, DESCRIBE:

ANY SERIOUS ACCIDENTS/ILLNESSES WHICH DID NOT REQUIRE HOSPITALIZATION? YES NO
IF YES, DESCRIBE:

ANY PROBLEMS WITH YOUR MEMORY? NO YES
IF YES, DESCRIBE:

HOW MUCH EXERCISE DO YOU GET ON A DAILY BASIS? _____

DO YOU EAT A WELL-BALANCED DIET? YES NO

IF NO, DESCRIBE ANY PROBLEMS WITH DIET:

DO ANY OF YOUR BIOLOGICAL RELATIVES HAVE A HISTORY OF HEALTH PROBLEMS, SUCH AS HIGH BLOOD PRESSURE, DIABETES, HEART DISEASE, ETC? YES NO
IF YES, DESCRIBE:

FAMILY OF ORIGIN

ARE YOU CLOSE TO MEMBERS OF YOUR FAMILY OF ORIGIN? YES NO
IF YES, WHO ARE YOU CLOSEST TO?

HAVE YOU HAD ANY SIGNIFICANT SEPARATIONS FROM CAREGIVERS
WHEN YOU WERE A CHILD? YES NO

IF YES, BRIEFLY EXPLAIN:

ANY HISTORY OF PHYSICAL ABUSE AS A CHILD/ADOLESCENT? YES NO

ANY HISTORY OF SEXUAL ABUSE AS A CHILD/ADOLESCENT? YES NO

ANY HISTORY OF EMOTIONAL ABUSE AS A CHLD/ADOLESCENT? YES NO

IS THERE ANY OTHER INFORMATION YOU WISH TO PROVIDE?

(Updated 5-30-07)