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NEW PATIENT – ADULT HISTORY FORM

Today's Date:_____

Name: _____

Date of Birth: _____ Age: _____

Gender: _____ Primary Language: _____

Contact Information

Street Address:_____

City:_____ State:_____ Zip Code: _____

Home Phone:_(_____)_____ Other Phone:_(_____)_____

Family

Significant Other's Name: _____

Relationship to client: _____

Age: _____ Educational Level: _____ Occupation: _____

Employer: _____

Do you have children? Yes ☐ No ☐

Name(s)	Age	Quality of Relationship

Relationship history: Married☐ Separated☐ Divorced☐ Never Married☐

Please list all who live with you:

Name	Age	Relationship to Client

Please describe other significant figures in your life. _____

_____

_____

Please describe cultural/ethnic identification and/or religious/spiritual affiliation and their role in your life. _____

_____

_____

FOR WHAT PROBLEM(S) ARE YOU SEEKING HELP? _____

_____

_____

_____

_____

_____

GENERAL BEHAVIOR (c*heck all that apply*):

- ○ Friendly, Outgoing
- ○ Shy
- ○ Easygoing, Calm
- ○ Irritable
- ○ Hardworking
- ○ Lazy
- ○ Prefer to be with others
- ○ Prefer to be Alone
- ○ Optimistic
- ○ Pessimistic
- ○ Caring
- ○ Uncaring
- ○ Cooperative
- ○ Stubborn
- ○ Confident
- ○ Expects Failure
- ○ Giving
- ○ Selfish
- ○ Respectful
- ○ Defiant
- ○ Take Risks
- ○ Cautious
- ○ Generally Happy
- ○ Generally Unhappy

Other: _____

_____

_____

PROBLEM PATTERNS OF THINKING

- ○ Worry a lot
- ○ Fearful
- ○ Obsessive
- ○ Compulsive
- ○ Odd & disturbing
- ○ Ruminate

Please describe: _____

_____

_____

PROBLEM BEHAVIORS

- ○ Compulsive
- ○ Repetitive
- ○ Odd habits
- ○ Messy
- ○ Inattentive
- ○ Short Attention Span
- ○ Distractible
- ○ Impulsive
- ○ Hyperactive
- ○ Accident Prone
- ○ Angry Outbursts
- ○ Argue with _____
- ○ Defiant, Oppositional
- ○ Fights
- ○ Lie
- ○ Legal Problems
- ○ History of Cruel to Animals
- ○ Reckless, Careless

Notes: _____

_____

_____

_____

CONCERNS ABOUT MOOD

- ○ Mood Swings
- ○ Sadness
- ○ Depression
- ○ Crying Spells
- ○ Irritable
- ○ Tense
- ○ Withdrawn
- ○ Bored
- ○ Nervousness
- ○ Anxiety
- ○ Overexcited/euphoric
- ○ Angry
- ○ Impatient

Notes: _____

_____

Appetite

☐ Decrease ☐ Increase ☐ Weight Changes

Additional Information: _____

_____

_____

Sleep

- ○ Nightmares
- ○ Insomnia
- ○ Night Terrors
- ○ Sleepwalking

Additional Information/Do you get enough sleep? _____

_____

_____

_____

SIGNIFICANT LIFE EVENTS

Please indicate any important events in your life (*check all that apply*):

- ○ Move/Change of residence
- ○ Change of jobs
- ○ Marital conflict
- ○ Separated
- ○ Divorced
- ○ Post-divorce problems
- ○ Remarried
- ○ Children/Step-children problems
- ○ Difficulty starting a family
- ○ Parenthood problems
- ○ Financial problems
- ○ Health problems/Illness
- ○ Job problems
- ○ Job loss
- ○ Other family problems
- ○ Rejection by family members
- ○ Suffered/Witnessed significant accident/injury
- ○ Other severe fright or trauma

○ Death of family member ○ Death of friend ○ Death of pet

Please describe & add important events. _____

_____

_____

_____

Social/Recreational Activities

What activities do you do for fun? *Please describe.* _____

_____

_____

How many hours per week do you engage in leisure activities? _____

Please describe your friendships. _____

_____

_____

_____

Are you satisfied/happy with your social life? *Please explain.* _____

_____

_____

ADULT EMPLOYMENT HISTORY

Are you currently employed? Yes☐ No☐

Occupation: _____

Employer: _____

How many hours per week? _____

Please describe the nature of the employment. _____

_____

Do you have problems with co-workers or supervisors? *Please explain.* _____

_____

_____

Are you satisfied with your job? *Please explain.* _____

_____

_____

Are you looking for a new job? Yes☐ No☐

*Please explain*_____

_____

_____

Please describe past employment history:

Employer	Dates	Description

Have you ever been fired? *Please explain.* _____

_____

LEGAL HISTORY

Have you ever been involved in criminal or civil proceedings? (*circle one*) Yes No

If yes, please explain. _____

_____

(*check all that apply*):

- ○ Suspended/Revoked driver's license
- ○ Conviction for misdemeanor
- ○ Conviction for felony
- ○ DUI/DWI
- ○ Shoplifting
- ○ Assault/Battery
- ○ Property Damage
- ○ Other

Please explain. _____

_____

_____

Have you ever been charged or arrested for any offense involving drugs or alcohol?

Yes ☐ No☐

If yes, please explain. _____

_____

Are you currently on probation? Yes☐ No☐

If yes, please explain the reason and terms of probation. _____

_____

_____

Is there a family history of legal problems? Yes☐ No☐

If yes, please explain. _____

_____

_____

Notes: _____

_____

_____

SMOKING HISTORY

Do you smoke cigarettes? Yes☐ No☐

How long have you been smoking? _____

School History

Did you ever repeat a grade? *Please explain.* _____

_____

Did you ever skip a grade? *Please explain.* _____

_____

- ○ Missed School Due to Illness
- ○ Skipped Classes/School
- ○ Learning Problems
- ○ Speech Problems
- ○ Poor School Work
- ○ Enjoyed school
- ○ Good School Work

Additional Information: _____

_____

_____

_____

MEDICAL HISTORY

Please describe your current physical health. _____

_____

_____

Are you currently taking medication? Yes☐ No☐

Please list and describe: _____

_____

_____

_____

Who is prescribing these medications?_____

_____

_____

_____

Have you ever had a serious accident or injury? Yes☐ No☐

If yes, please explain. _____

_____

_____

Have you ever been medically hospitalized? Yes☐ No☐

If yes, please explain. _____

_____

_____

Have you ever undergone surgery? Yes☐ No☐

If yes, please explain. _____

_____

_____

Are you sexually active? Yes☐ No☐

*Comments*_____

_____

Is there a family history of chronic illness or disease? Yes☐ No☐

If yes, please explain. _____

_____

_____

_____

Notes: _____

_____

_____

ALCOHOL AND SUBSTANCE USE ASSESSMENT

What is your current use of alcohol like? *Please describe frequency and amount of alcohol use.* _

_____

_____

Has this ever been a problem for you? ☐ Yes ☐ No

Have you ever been in treatment for this? ☐ Yes ☐ No

Please explain. _____

_____

Have you ever tried to stop drinking and/or using drugs? ☐Yes ☐ No

Is there a family history of alcohol and/or substance abuse? ☐Yes ☐No

If yes, please explain. _____

_____

_____

SUICIDE ASSESSMENT

Do you currently have suicidal thoughts/ideation? *Please describe.* _____

_____

_____

If you were to experience suicidal thoughts, what would keep you from acting on them? _____

_____

_____

Have you previously had suicidal thoughts/ideation? Yes☐ No☐

Have you ever attempted suicide? *Please describe.* _____

_____

_____

Do you know anyone who has committed suicide? Yes☐ No☐

Please describe your relationship to this person. _____

_____

_____

ANGER CONCERNS

Do you have problems with anger? Yes☐ No☐

If yes, please describe. _____

_____

How do you deal with frustration? *Please describe.* _____

_____

_____

Is there a family history of aggressive behavior, assaults, violence toward others? Yes☐ No☐

If yes, please explain. _____

_____

_____

_____

ABUSE ASSESSMENT

Have you ever experienced physical, sexual, and/or emotional abuse? *Please describe.* _____

_____

_____

_____

_____

Have you ever been a perpetrator of abuse? Yes☐ No☐

If yes, please explain. _____

_____

_____

Is there a family history of physical, sexual, or emotional abuse? Yes☐ No☐

If yes, please explain. _____

_____

_____

Have you ever witnessed acts of domestic violence? ☐Yes ☐No

Has your child ever witnessed acts of domestic violence? ☐Yes ☐No

If yes, please explain. _____

_____

_____

Previous Mental Health Treatment

Previous psychotherapy? Yes ☐ No ☐

If yes, please indicate the setting, frequency, and length of treatment (optional - with whom)

_____

_____

_____

What was the treatment experience like? _____

_____

_____

_____

_____

Have you ever taken psychotropic medication? ☐Yes ☐No

Please describe. _____

Are you currently taking psychotropic medication? ☐Yes ☐No

Please describe. _____

_____

Is there a family history of mental health problems? Yes☐ No☐

If yes, please explain. _____

_____

_____

_____

Have you ever been psychiatrically hospitalized? Yes☐ No☐

If yes, please indicate the facility: _____

Dates of treatment: _____

Please describe the reason for hospitalization: _____

_____

What was the treatment experience like? _____

_____

_____

Have you tried complementary or non-traditional methods of dealing with your current discomfort? Yes☐ No☐

Please explain. _____

_____

_____

_____

Thank you for completing this form. What else should I know about you?

_____

_____

_____

PLEASE BRING THIS FORM WITH YOU TO OUR FIRST SESSION.