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ADULT BACKGROUND AND HISTORY FORM

LEGAL NAME: ____ NICKNAME: _________________

DATE OF BIRTH: __________________ GENDER: FEMALE MALE OTHER AGE: ___________

ADDRESS: ____

CITY: ____________________________ STATE: ___________ ZIP: ____________

HOME PHONE #: _______________________________ May I leave a message? YES/NO

CELL #: _______________________________________ May I leave a message? YES/NO

EMAIL: ____

Occupation: ____

Employer: ____

Emergency Contact: ____ PHONE#: _______________________

Who referred you to me: ____

Primary Care Physician: _________________________________ Phone#: ______________________________

CURRENT CONCERNS

Major reasons for coming in and why at this time:

____

____

____

____

____

When did you first notice the problem?

____

____

____

Do you have any additional concerns?

____

____

____

What have you tried to remedy the problem(s)?

____

____

____

Please list the names of other mental health professionals consulted prior to coming to see me:

Name: ____ Type of professional: ________________________

Date of consult: _______________ Reason for consult: ____

Name: ____ Type of professional: ________________________

Date of consult: _______________ Reason for consult: ____

FAMILY HISTORY

Please list all people living in the household (please list any additional people on back of this page if necessary):

Name Age Gender Relationship to client

____ _____ ______ ___________________________________

____ _____ ______ ___________________________________

____ _____ ______ ___________________________________

____ _____ ______ ___________________________________

____ _____ ______ ___________________________________

Spouse/Partner/Significant Other

Name: ____ DOB: ____________________ Age: ____________

Quality of your relationship: ____

Do you have children: Yes No

If yes, please provide details:

Name	DOB	Age/Grade	Quality of your relationship

Extended Family relationships:

Parents:	Age	Alive / Deceased	Reason for death	Quality of your relationship

Siblings:	Age	Alive/ Deceased	Reason for death	Quality of your relationship

Medical / Developmental History

As far as you know, were there any problems or concerns with your mother's pregnancy or delivery of you (for example, emotional stress, drug/alcohol use, accidents or injuries, pre-term labor, toxemia/eclampsia, unplanned C-section, fetal distress)?

Yes No If yes, please provide details:

As far as you know, did you have any difficulty learning to walk, talk, or sit up on time?

Yes No If yes, please provide details:

How long has it been since your last physical examination? ______________________________

What were the results?

Any history of hospitalizations or surgeries? YES NO If yes, please provide details:

Any current medical problems? YES NO If yes, please provide details:

____

____

Current medications (please include both prescription and non-prescription)

Medication	Dosage	Reason for taking

Psychiatric History

Have you ever been hospitalized for a psychological of psychiatric condition? YES NO If yes, please provide details:

____

____

____

____

Do you have any history of suicide attempts? YES NO If yes, please provide details:

____

____

____

Do you currently have thoughts or urges to harm yourself or others? YES NO If yes, please describe:

____

____

____

Do you currently have suicidal thoughts or plans? YES NO If yes, please provide details:

____

____

____

____

Have you or any of your blood relatives had any of the following?

	Self	Other	If other, who?
Alcoholism			
Anxiety			
Bipolar Disorder			
Depression			
Diabetes			
Drug Abuse			
Epilepsy			
Headaches			
High Blood Pressure			
HIV			
Physical Abuse			
Schizophrenia			
Sexual Abuse			
Suicide Attempt			
Thyroid Disease			

<u>Drug / Alcohol Use</u>

Do you smoke cigarettes? YES NO If yes, how many per day? ______________________________________

Have you ever smoked cigarettes? YES NO If yes, when did you quit? _______________________________

How much caffeine do drink per day, including coffee, tea, and soda?

None | 5-6 cups per day

1-2 cups per day | 7-10 cups per day

3-4 cups per day | 10+ cups per day

How much alcohol do you drink in a week?

I never drink | 5-10 drinks

0-1 drink | 10+ drinks

2-4 drinks

Do you ever drink more heavily? YES NO If yes, please provide details:

Have you ever used drugs recreationally? YES NO If yes, please provide details:

Do you use drugs recreationally now? YES NO If yes, please provide details:

Educational / Academic History

How would you describe your grades in school?

Worse than average Average Better than average

What was your best subject in school?

What was your most challenging subject in school?

Did your parents and teachers think that you did as well as you could?

What is your highest level of education?

Do you have trouble with your temper? If so, have you ever hurt anyone or damaged property as a result?

Have you ever been arrested or in trouble with the law?

CHECK THE SYMPTOMS THAT HAVE CAUSED YOU TO SCHEDULE AN APPOINTMENT

SYMPTOM		SYMPTOM	
I am sad or tearful		My stomach is often in a knot	
I don't enjoy things the way I used to		My heart often races	
I have suicidal thoughts		I feel panicky	
I feel hopeless about the future		I have difficulty going out alone	
I feel like hurting myself		My mind often races	
I feel like hurting others		I am behaving impulsively	
I am having sleeping difficulties		I have unusual thoughts	
My eating habits have changed		My moods are very changeable	
I have difficulty concentrating		The same thoughts keep running through my mind	
I worry about every little thing		I repeatedly check on the things I have done	
My hands often shake		Sometimes I do things over and over again	
I feel very irritable		I have problems with my temper	
I feel very anxious or fearful		I get or receive messages from the TV or radio	
People are talking about me		I hear voices or see things that other people don't	
I think I have an eating problem		I have a particular fear or phobia	
Please explain:		Please explain:	

HAVE YOU HAD ANY OF THE FOLLOWING STRESSES OVER THE PAST YEAR?

I have lost my job		I have had a miscarriage or abortion	
Someone close to me has left		I have behaved violently or abusively towards someone	
I or someone close to me has been ill		I have been the victim of violence or abuse	
Someone close to me has died		I have given up alcohol	
I have had a baby		I have been involved in or witnessed an accident	
I am suffering from grief. Explain:		I am worried about my physical health. Explain:	
Are you pregnant?			
Are you planning on getting pregnant?		Are you on birth control pills?	

How would you describe your mood most of the time?

Normal and fairly stable

Anxious or nervous

Depressed, sad, or blue

Labile: Mood changes a lot

Other: ____________________________

What else would you like me to know? Please add any additional information you think it relevant or address any concerns not addressed above.