

**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):**

NAME(S) 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: .

	<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>
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:

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

IF YES, EXPLAIN:

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## **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:

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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:

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

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

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

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

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

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

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

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HOW MUCH EXERCISE DO YOU GET ON A DAILY BASIS? \_\_\_\_\_

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DO YOU EAT A WELL-BALANCED DIET? YES NO

IF NO, DESCRIBE ANY PROBLEMS WITH DIET:

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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:

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## **FAMILY OF ORIGIN**

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

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

IF YES, BRIEFLY EXPLAIN:

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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 CHILD/ADOLESCENT? YES NO

IS THERE ANY OTHER INFORMATION YOU WISH TO PROVIDE?

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(Updated 5-30-07)