PERSONAL & FAMILY HISTORY
Adult Form

Date:_____

Name:_____ Date of Birth:_____

Address:_____

Home Phone_____ Buisness Phone_____hrs._____

Sex_____ Ethnic Origin_____ Social Security Number_____

What is the current problem? _____

_____

Who referred you ?_____

Marital history (partner can refer to spouse/fiancee/ long term relationship)

Current Marital Status_____Years Married_____

Partner/Spouse's Name_____ Age_____

Partner/Spouse Employed? Yes No Where_____

How old were you when you were first married?_____

Were either of you married before? Yes_____ No_____

If yes, please answer the following:

	Husband	Wife
Date(s) of previous marriage(s)	_____	_____
Date(s) previous marriage(s) ended	_____	_____
Reason(s) previous marriage(s) ended	_____	

Give the names and ages of everyone living in the same house with you,

Name	Age	Relationship
_____		
_____		

Give names and ages of any children who have moved out of your house or who are not living with you:

Name	Age	Approximate date moved out
_____		
_____		

 Name_____ Date _____

Employment History:

Are you employed?_____FT PT volunteer in-the -home

Firm and position:_____years_____

What other types of jobs have you had? _____ _____

_____

Describe any problems on the job (past or present):_____

_____

Have you ever been in the armed forces _____yes _____no

If yes which branch?_____rank_____rating_____

Date enlisted? _____Date and type of discharge_____

Educational History:

Are you still in school? Yes No Name of school_____ Graduation date_____

Years of Education_____Highest Degree_____

Have you ever had any learning problem ? _____

Have you ever repeated or skipped a grade? _____

Were you ever expelled? _____

Attendance problems? _____

What type of student were/ are you? _____

Legal Issues:

Have you ever had any dealings with the legal system? ____Yes _____No

If yes, what was the problem and what age were you at the time ? _____

Are there pending or anticipated legal concerns (including custody issues) __Yes _____No
If "yes" Explain:

Social Activities

What do you do for fun? What are your hobbies? _____

About how many close friends do you have? _____

 Name_____ Date _____

Medical History:

Primary Physician:_____ Last Seen/Reason:_____

Major surgeries / dates_____

Serious illnesses or injuries_____

Are you aware of having experienced ...
A serious physical or sexual trauma? (assault/rape/ child abuse)_____

Emotional/mental trauma_____

A natural disaster?_____

List any major health problems for which you currently receive treatment:

_____

Allergies, include medications:_____

List any medications you are now taking (dosage and frequency):_____

What non-prescription drugs do you use regularly? _____

Is there anything you do to excess (alcohol, drugs, eating, gambling, shopping, etc.)? Yes No

If yes, what?_____

Please list any/all drug use Here

Do you ...

			amount / frequency
smoke?	yes	no	
use alcohol?	yes	no	
exercise?	yes	no	

Have you ever received evaluation or treatment for a drug or alcohol use or a related problem? yes no

Explain_____

Have you ever gotten a DUI? yes no When_____

What health concerns are there in your family history?(e.g. diabetes, huntingtons, heart disease)?

Family History

Are your parents still living together? ____yes ____no Explain:_____

Describe your father:_____

_____

Age:_____Deceased?_____Year _____

Name_____ Date _____

Symptoms : Rate each concern : 0 =not a problem
1 = sometimes a problem/ mild problem
2= frequent/ serious problem

_____sad/depressed	_____loss of appetite	_____headaches
_____difficulty sleeping	_____weight loss	_____upset stomach
_____difficulty concentrating	_____weight gain	_____sweating
_____mood swings	_____sexual problems	_____lightheaded/dizzy
_____dwelling on problems	_____hot/cold spells	_____short of breath
_____angry feelings	_____suicidal thoughts	_____feeling worthless
_____withdrawing	_____boredom	_____loneliness
_____hopelessness	_____low energy	_____talkative
_____nervous/tense	_____many worries	_____restless
_____panicky	_____too much energy	_____shaky/trmbling
_____hard to trust anyone	_____racing thoughts	_____many fears
_____much guilt	_____easily frustrated	_____nightmares
_____confused	_____memory problems	_____fatigue
_____feel used by others	_____strange experiences	_____ senseless behaviors
_____ thoughts of harming someone	_____other_____	

What stressors in your life are influencing or being influenced by this problem?

_____marital _____ children _____job _____health _____financial

_____friends _____other relatives _____legal _____ school _____other: _____

Person to notify in case of emergency : _____ _____
(Name) (Relationship)

Address(if different from your own):_____

Home Phone (if different from yours):_____Business Phone:_____

Please add any additional information which you feel may be useful to us:

_____

_____

_____
Signature

Thank you for completing this questionnaire.

 Name_____ Date _____

Describe your mother:_____

_____

Age:_____Deceased?_____Year _____

List your brothers/sisters/ with ages; circle any step siblings_____

_____

Has anyone in the family ever :

relationship

committed suicide? yes no relationship_____

received inpatient psychiatric treatment ? yes no relationship _____

other psychological/psychiatric treatment? yes no relationship_____

history of emotional problems/ mental illness? yes no relationship_____

have a history of substance abuse? yes no relationship_____

have a history of physically, sexually, emotionally abusing others? _____

Religious Preference_____

Current Problem:
On a scale of 1 -10 with 1 being minimally disturbing and 10 being entirely unbearable rate your problem today.

Was there a precipitating factor or change in life circumstances having to do with this problem?

How long have you been concerned about this?

What have you tried in the past?

Have you received psychiatric or psychological help or counseling before? yes no

If you have, please explain: _____

Name of facility/provider_____

Diagnosis(if known)_____

Type of treatment: psychotherapy/ medication/ hospitalization/other_____