CLINICAL HISTORY: ADULT

All information provided is treated in strict confidence, according to HIPAA regulations.
Give as much information as you can. The clinician will go over the details with you.

Name: _____ **DOB: _____ Age: _____**
Address: _____ **Today's date: _____**
_____ **Ph#: _____**
SSN: _____ **Education: _____**

Name of person assisting patient to complete this form (Please include relationship i.e. spouse, friend, sister/brother etc.):_____

Personal and Family Information:
Current Living Situation*: Please check all that apply*
□ Single □ Significant Other □ Common law marriage (How long? ____)
□ Married (How long?_____) □ Divorced (How recently?_____) □Separated (How long?_____)
□ Married in the past (Times?_____) □ Widowed (How long?_____)
Children: □ Yes □ No Ages: _____
With whom are you currently living? _____
*If children are not living with you, do you have regular contact with them? □Yes □ No *How often? _____; Particular concerns with children? □Yes □ No *If yes, please explain- _____ _____ Any other information about your current living situation? _____
_____
_____

Growing up experiences:
Where were you born? _____ Where have you lived most of your life?_____
How long have you lived here? _____ How many children in your family growing up? _____
What was your position (e.g. #1, #4) in the family? _____
Who raised you? _____ If you were raised by someone other than parents, why was this? _____
Were your parents divorced? □Yes □ No
Did you have regular contact with each parent during childhood? □Yes □ No
If not, why? _____
How was your family life growing up? _____
_____
Any history of abuse as a child or teenager? □Yes □ No Any abuse as an adult? □Yes □ No
Please check all that apply.
□ Physical (By whom and how long? _____)
□ Emotional /□Verbal/ □Mental (By whom and how long? _____)
□ Sexual (By whom and how long? _____)
□ Neglect (By whom and how long? _____)
□ Other trauma (significant death/ fire/ scare/ or any other major life event, please explain)? _____
_____

Education:

How far did you go in formal school? _____ What high school did you attend?_____
What grades did you make in school? _____ If you dropped out of school, why?_____
In school, were you in: (please check) ☐regular education classes ☐ Special Education classes ☐Both
What classes were special education?_____
Did you have a Learning Disability? ☐Yes ☐ No *If yes, what type?_____
If you didn't finish high school, did you earn a GED? ☐Yes ☐No
Have you attended: (Please check) ☐ Vocational ☐Technical ☐Business ☐Trade Course(s) ☐ None
What school(s) did you attend_____ Did you complete the program? ☐Yes ☐ No
Have you attended college? ☐Yes ☐ No *What college(s) have you attended?_____
What area(s) did you study in college or other school? _____
Do you have a college degree? ☐Yes ☐No *What year did you receive it? _____
NOTES:_____
_____
_____
_____

Work History:

What kinds of jobs have you had? _____
Are you employed now? ☐Yes ☐ No How long have you been out of work? _____
Why did you leave your last job? _____
Have you been seeking employment? ☐Yes ☐No
NOTES_____
_____
_____
_____

Physical Health History: ***(Please DO NOT address depression, anxiety, ADHD, or other mental health conditions here)***

How is your physical health? (Please check) ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐Very Poor
What health problems do you have? _____
_____
NOTES: _____
_____
_____

What treatment(s) have you had for these problems? ☐Medication ☐Surgery ☐None
Treating physician(s) _____
_____
Any other injury, accident or surgery in life? _____
_____

Have you had a brain trauma? (Please check all that apply) ☐Head injury ☐Stroke ☐Brain surgery
☐Seizures ☐Electrical shock ☐Loss of oxygen ☐Unconsciousness ☐Other impact to the brain

Emotional Health/Psychological Information: *(Focus on symptoms only in this section. Treatment comes next)*

How do you feel emotionally? *(Please check)* ☐Excellent ☐Good ☐Fair ☐Poor ☐Very Poor

Frequent moods: *(Please check all that apply)* ☐Depression ☐Anxiety and stress ☐Excessive anger

DETAILS:_____

_____

_____

_____

_____

_____

_____

Thoughts of suicide in your lifetime? ☐Yes ☐ No ; ☐Past ☐Present (If yes, when and how many times?_____

If you have attempted suicide, how have you tried to kill yourself? _____

_____

Were you taken to the hospital because of the suicide attempt(s)? ☐Yes ☐No If yes, what treatment(s) did you receive? _____

Date of most recent suicide attempt? _____

Serious consideration/plans of suicide at this time? ☐Yes ☐ No *If Yes, Explain: _____

_____

Have you had any hallucinations? *(Please check all that apply)*

☐Auditory ☐Visual ☐Tactile (touch) ☐Other: _____

If auditory, whose voice did you hear (male or female)? _____

How many voices? _____ How often? _____

What was being said? _____

When did you begin to have auditory hallucinations? _____

If visual, what did you see?_____ How often?_____

If tactile what do you feel?_____

Do you still have these experiences? ☐Yes ☐ No When did they begin?_____

Do you have delusions (strange ideas about yourself, like you were somebody else)? ☐Yes ☐ No

What are/were they about? _____

Do you still have them? ☐Yes ☐ No How often do you have these thoughts? _____

When did the delusions begin? _____

NOTES:_____

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If you have panic attacks, how often do you have them (times per week/month)? _____

(Check all that apply)

☐racing heart	☐sweating	☐trembling or shaking	☐shortness of breath
☐sense of choking	☐fear of dying	☐agitation	☐chills
☐sense of terror	☐nausea	☐hot flashes	☐chest pain or discomfort
☐dizziness or lightheadedness		☐fear of losing control	

☐Other (please explain) _____

How do you manage these episodes?_____

Treatment for emotional problems:

Have you ever seen a mental health professional? *(please check all that apply)*

□Psychiatrist □Psychologist □Counselor □Therapist

Name: _____ When did you see him/her? _____

Are you seeing someone now? □Yes □ No If yes, who? _____

What psychiatric ***diagnosis/diagnoses*** have you been given? _____

Who diagnosed you?_____ When were you diagnosed?_____

Have you ever been hospitalized for psychiatric treatment? □Yes □ No *If yes, give details (name of hospital, year, length(s) of stay) _____

_____

Past medication use for emotional problems? _____

Current medications for emotional problems? _____

Who prescribes it? _____ *When did you start taking it? _____

Is your treatment effective now? □Yes □ No How is it helping you? _____

_____

NOTES:_____

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Current stressors in your life that contribute to your emotional problems -

(Check all that apply):

□Financial problem □Inability to pay bills □Unemployment □Relationship problems

□Marriage problems □Recent divorce □Health problems □Disabling condition

□Lack of family support □Single parenting □Living alone □No child support

□Transportation problems □Past trauma □Inactivity □Social isolation

□Loss of career □Chronic pain □Physical restrictions □No health insurance

□Children/family problems □Inability to be productive □Slow/no medical progress

□Change in quality of life □Recent death(s) (who? _____)

□Other stressors:_____

Have you had any history of Attention Deficit/Hyperactivity Disorder (ADHD/ADD)? □Yes □ No

When were you diagnosed? _____ Who diagnosed you? _____

Which medication(s)? □Ritalin □Adderall □Dexedrine □Vyvanse

□Metadate □Concerta □Strattera □None □Other_____

Are you still on medication? □Yes □ No

Symptoms of ADHD/ADD that you have: *(Please check all that apply)*

□Attention span/concentration problems □Impulsivity (doing things without thinking of consequences)

□Overactivity/ hyperactivity □Social aggressiveness □Other symptoms? _____

_____

NOTES:_____

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Substance Abuse History:

Do you smoke cigarettes? ☐Yes ☐ No *How many, how often? _____
How long have you smoked? _____ Date you quit smoking? _____
Do you drink alcohol? ☐Yes ☐ No *How much and how often? _____
Any abuse of **alcohol** in your lifetime? ☐Yes ☐ No Are you an alcoholic? ☐Yes ☐ No
For how long have you abused alcohol? _____ When did you stop? _____
Have you been in treatment for alcoholism? ☐Yes ☐ No
If yes, name of treatment center and when? _____
Are you in an active recovery program now? ☐Yes ☐ No Name of program: _____
Do you go to treatment at present (e.g. AA, group meetings, individual sessions)? ☐Yes ☐ No
Have you had relapses? ☐Yes ☐ No If yes, how often? _____
Do you or have you abused **street drugs** or **medication** in your lifetime? ☐Yes ☐ No
When did you start? _____
Which drugs? *(please check all that apply)*

☐ Marijuana ☐Cocaine ☐ Heroin ☐Methamphetamine
☐Prescription Drugs ☐Other (Please list):_____
Do you use drugs now? ☐Yes ☐ No *Which ones? _____
If yes, how much and how often? _____
When did you stop using drugs? _____
Have you been in chemical dependency treatment? ☐Yes ☐ No *How many times? _____
Current recovery program? _____
Any relapses? ☐Yes ☐ No
Have you ever been **arrested**? ☐Yes ☐ No *How many times?_____
If yes, what were the charges you were arrested for? (include dates) _____
_____
Have you been to prison? ☐Yes ☐ No *How many times? _____
Where? _____ When were you last released? _____
Are you currently on probation or parole? ☐Yes ☐ No *For how long? _____
Any legal problems pending (i.e. court dates, warrants, etc.)? ☐Yes ☐ No
Please explain: _____
_____

Comments:_____
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