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ADULT PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT INFORMATION

Name: _____

Address: _____
(Street)

_____
(City) (State) (Zip code)

Telephone: (W) _____ (H) _____ (Cell) _____

Email address: _____

Date of birth: _____ Current age: _____

MARITAL STATUS:

___ Single/ Never Married ___ Married ___ Living Together ___ Divorced ___ Widowed

Date of Current Marriage: _____

How many times have you been married (if more than once)? ____

Information About Prior Marriages:.

	Date of Marriage	Date of Divorce	Separations
1			
2			
3			
4			

EDUCATION/OCCUPATION:

What is the highest level of education that you have completed? _____

What is your current occupation? _____

Please list any prior occupations and include dates:

	Occupation	Dates
1		
2		
3		

REFERRAL SOURCE:

How were you referred to my practice? _____
(Over)
If by a person, may I contact to thank them for the referral? ___ Yes ___ No

EMERGENCY CONTACT:

In the event of an *emergency* whom could I contact if I was unable to reach you:

Name: _____ Relationship: _____

Telephone: (H) _____ (W) _____ (Cell) _____

FAMILY INFORMATION:

Spouse/Significant Other: _____

Date of Birth: _____ Age: _____ Telephone: (W) _____ (Cell) _____

Occupation: _____ Employer: _____

Who lives in your home?

Relationship	Date of Birth	Age	Step-sibling

At any time have you been particularly concerned about any of your children, and if so please provide details.

HEALTH HISTORY
(You are being asked these questions to rule out any possible physical conditions that might be affecting your mood, or causing any of your symptoms. Completeness and honesty in your responses will allow us to work together more effectively).

Name of Primary Care Physician: _____

Address: _____

Physician's telephone number: _____ Date of Last Physical: _____

Please list any acute or chronic conditions for which you are currently being treated and any medications you are taking:

MEDICATIONS

Medication	Dosage	Prescribing Physician	Condition – Start Date

HOSPITALIZATIONS:.

Date of Hospitalization	Name of Hospital – Location	Condition	Physician

ALCOHOL

Do you drink alcoholic beverages? ___ Yes ___ No How often do you drink? _____

What do you drink? _____

What are your weekday drinking habits (list beverages and amount/quantity)? _____

_____

What are your weekend drinking habits (list beverages and amount/quantity)? _____

Do you ever drink to get drunk? ___ Yes ___ No

Have you ever been a binge drinker? ___ Yes ___ No; Are you currently a binge drinker? ___ Yes ___ No

Do you drink to change the mood you are in? ___ Yes ___ No

Have you ever had any alcohol-related driving offenses? ___ Yes ___ No When? _____

Has anyone ever told you about things that occurred the previous night which you are unable to recall? ___ Yes ___ No

Do you ever *need* a drink first thing in the morning? ___ Yes ___ No

Have alcohol or any other drugs affected you or any other members of your extended family, this includes grandparents, aunts and uncles, in-laws, or any other relatives?
___ Yes ___ No
If *yes*, please provide details:

SMOKING/CHEWING:

Are you a smoker? ___ Yes ___ No

Have you been a smoker? ___ Yes ___ No If *yes*, when did you quit? _____

Have you resumed smoking at any time? ___ Yes ___ No

If *yes*, what were the circumstances?

Do you chew tobacco? ___ Yes ___ No Have you ever chewed tobacco with any frequency? ___ Yes ___ No

CAFFEINE:

Do you drink caffeinated beverages? ___ Yes ___ No

What beverages do you consume and in what quantities? _____

PRESCRIPTION MEDICATIONS

Have you ever abused prescription medications? ___ Yes ___ No

If *yes*, please specify the medications and when.

USE OF ILLICIT DRUGS

Please provide details about *past* and *present* use, and include Type, Frequency, Amount used in time frames (*Your honesty here is very important to avoid misdiagnosis)*

Present

Past

EATING ISSUES

Have you ever been treated for an Eating Disorder, or do you suspect that you may have one? ___ Yes ___ No

Do you have any concerns about your eating habits or has anyone expressed concerns? (Please describe)

SLEEP

How many hours of sleep do you get? ___ On a weekend night ___ On a week night

In the morning do you typically feel as though you have had a good night's sleep? ___ Yes ___ No

Are you taking any medications to help you sleep; and if *yes*, please specify.

Have you been diagnosed with sleep apnea? ___ Yes ___ No

If yes, what has been prescribed?

EXERCISE

Do you engage in any regular form of exercise? ___ Yes ___ No

What do you do for exercise (and frequency)?

WATER

How many ounces of water do you drink daily? _____ ounces

PRIOR MENTAL HEALTH TREATMENT

Have you ever seen a Counselor or a Psychotherapist at any time for Individual, Couples, Family or Group Counseling or Therapy?
___ Yes ___ No

If *yes*, please provide the following information:

Dates	Name of Therapist	Location	Reason for Treatment	Type of Treatment

If you have previously seen a therapist/counselor, What did you find helpful; and what was not helpful so we can learn from your prior experiences.

Have you recently thought about suicide (any time in the past few days, weeks, or months)? ___ Yes ___ No

If *yes*, please tell me about the thoughts you have been having.

Have you ever made any suicide attempt(s)? ___ Yes ___ No If *yes*, how many times? _____

Date of Attempt	Method	Triggering Event

Were you hospitalized? ___ Yes ___ No Did you go to an Emergency Room? ___ Yes ___ No

Have you ever known anyone who committed suicide i.e., extended family, friends, a coworker, etc? ___ Yes ___ No

Please provide details.

Has anyone in your family ever been treated for any type of mood disorder or mental health issues (including members of your extended family)?

TRAUMA

Have you or anyone in your family experienced any of these traumatic events:

___ Assaulted by a stranger ___ Assaulted by someone you know ___ Child Abuse, Emotional ___ Child Abuse, Physical

___ Child Abuse, Sexual ___ Domestic Violence ___ Fire ___ Held Hostage

___ Kidnapped ___ Rape ___ Robbery ___ War Zone/Military Combat

STRESSORS

___ Job Loss or Change ___ Unemployment ___ Bankruptcy ___ Foreclosure

___ Auto Accident ___ Legal Problems ___ Diagnosis of illness ___ Change in household Composition

___ Ending of a Significant relationship ___ Involvement of Child Protective Services ___ Death(s) ___ Deployment(s)

MILITARY HISTORY

Have you or any members of your family served in the military? ___ Yes ___ No

If *yes*, names and relationship to you.

ADDITIONAL INFORMATION

In the past year or so have you experienced any significant life changing events (i.e., job loss/change, assault, birth, deaths, relocations, job promotions, legal matters, changes in your financial situation i.e., bankruptcy, foreclosure; illnesses of yours or any extended family members), please tell me about these.

If you were to take a few moments to consider the reasons why you are currently seeking therapy, what might those be?

Do you have any specific concerns that you would like to make sure that we address in treatment?

Do you have any spiritual concerns that you would like to make me aware of?

What do you hope to accomplish in your treatment?

How might you know that therapy has been helpful to you?

Thank you for taking the time to complete this detailed history to help me learn more about you and how I might be the most helpful to you.