

ADULT HEALTH HISTORY AND PATIENT INFORMATION

Please complete this form and bring it with you to your first session.

Biographical Information

Name: _____

Address: _____

Date of Birth: _____

Age: _____

Ethnicity/Race: _____

Sexual Orientation: _____

Relationship Status: (circle one) single / married / divorced / remarried / _____

Education: _____

Occupation: _____

Employed: (circle one) full-time / part-time / not employed outside the home

Referred by: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact's Relationship to the Patient: _____

Home Phone: _____

Is it OK to leave a message? No Yes

Cell Phone: _____

Is it OK to leave a message? No Yes

Work Phone: _____

Is it OK to leave a message? No Yes

Email: _____

Is it OK to email you? No Yes

Health/Medical History

How would you describe your physical health? Excellent Good Fair Poor

Any significant medical issues (current/past)? No Yes

If yes, please describe: _____

Date of last physical exam? _____ Allergies: _____

Any past hospitalizations, surgeries, or serious injuries? No Yes

If yes, please describe _____

Have you had any past head injuries or injuries that resulted in a loss of consciousness? No Yes

If yes, please explain _____

Any family members with psychiatric or substance abuse problems (current/past)? No Yes

If yes, please describe _____

Have you ever been hospitalized for psychiatric reasons? No Yes

If yes, please describe _____

Have you ever tried to harm or kill yourself? No Yes

If yes, please describe _____

Have you ever experienced suicidal thoughts? No Yes

If yes, please describe _____

How much alcohol do you currently consume? _____ drinks per week

Do you currently use recreational drugs? No Yes How often? _____

Previous Mental Health Treatment

Have you ever seen anyone for psychotherapy? No Yes

If Yes, for how long? _____

Are you currently under the care of a psychiatrist/psychologist/therapist? No Yes

If Yes (Name/Location) _____

Do you have a primary care physician (or clinic)? No Yes

If Yes (Name/Location) _____

What medication(s) are you currently taking, including psychiatric and other medications?

What psychiatric medication(s) have you taken in the past?

Please describe the concerns that have brought you to seek therapy at this time.
