Adam J. Rodríguez, Psy.D.
Clinical Psychologist, PSY25105
(415) 373-3645

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

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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? _____

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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.

_____

_____

_____

_____

_____