Medical History Form | Adult

child&familydevelopment

Today's date:

IDENTIFYING INFORMATION:

Name:

Date of birth: Age: Sex: M F

Address: City: State: Zip:

Home phone: Other phone:

Race (optional): Marital status:

Primary physician:

Address: City: State: Zip:

Referred by:

Employer: Work phone:

Other family members living with you:

Name	Relation to you

REASON(S) FOR REFERRAL/CURRENT CONCERN(S)/PROBLEM(S):

1.

2.

3.

4.

How long have you had these concerns?

Are you taking any medication? Yes No

Please list:

How do you believe we can best help you with your concern(s)/problem(s)?

List previous psychological/psychiatric treatment:

Year	Doctor's name	Treatment	Location	Length of treatment

Describe nature of concern(s)/problem(s), if different from current ones:

What was helpful/unhelpful about prior treatment(s)?

PAST MEDICAL HISTORY:

Significant Illnesses		Hospitalizations		Surgeries	
Year:	Date:	Reason:	Date:	Type:	Date:

Check if you experience or have experienced any of the following:

Physical concerns:	✔	When	Explanation
Headaches			
Chronic illness			
Seizures/motor tics			
Digestive problems			
Muscle tension			
Sleep problems			
PMS			

Emotional concerns:	✔	When	Explanation
Panic attacks			
Obsessive thoughts			
Compulsive behaviors (e.g. excessive hand-washing)			
Unusual or excessive fears (e.g. fear of flying)			
Restlessness			
Sadness			
Loss of interest in normal activities			
Sexual concerns			
Low self-esteem			
Fatigue/low energy level			
Uncontrollable crying			
Suicidal feelings/thoughts			
Feelings of hopelessness			

PAST MEDICAL HISTORY (continued):

Emotional concerns:	✔	When	Explanation
Easily upset			
Grief/death issues			
Irritability			
Excessive energy			
Periods of euphoria			
Mood swings			
Eating problems			
Excessive bodily concerns			
Easily startled			
Nightmares/flashbacks			
Identity issues			
Occupational stress			
Disturbing/intrusive thoughts			

Attentional concerns:	✔	When	Explanation
Difficulty sitting still			
Difficulties with attention and concentration			
Procrastination			
Difficulty organizing self			
Easily overwhelmed			
Poor money management			
Inefficient			
Problems listening			
Auditorily distractible			
Visually distractible			
Frequent job changes			
Underachievement			
Poor planning			
Problems with task completion			
Impulsive behaviors (e.g. acting before thinking)			
Low frustration tolerance			

Conduct concerns	✔	When	Explanation
Difficulty controlling anger			
Over-dependence on others			
Interpersonal problems			
Argumentative			
Excessive gambling			
Aggressive behaviors			
Lying			
Urges to steal			
Nonconforming/rebellious			
Insensitive to danger			
Self-destructive behaviors			

PAST MEDICAL HISTORY (continued):

Social/interpersonal concerns	✔	When	Explanation
Parenting issues			
Marital problems			
Social isolation			
Critical towards others			
Suspicious of others			
Discomfort with groups			
Abused or neglected as a child			
Excessively self-focused			

Do you currently use alcohol or drugs? Yes No

Have you used alcohol or drugs in the past? Yes No

Substance	First used	Amount typically used	Times used per week

Briefly describe any problems you experienced growing up (e.g. at home, at school, with friends, in intimate relationships, child abuse, etc.):

Did you ever receive any psychological/educational testing? Yes No

Please explain:

EDUCATIONAL BACKGROUND:

School	Grades completed diploma/degree	Grades earned	Years attended
Elementary/Middle Schools:			
High School:			
College:			
Graduate School:			

EMPLOYMENT BACKGROUND:

Describe any work-related problems, if applicable:

Number of jobs in the past 5 years:

On a scale of 1 to 10 (1=low – 10=very satisfied), rate your satisfaction at work:

On a scale of 1 to 6 (1=Most – 6=Least), rate your primary life concerns *(do not use the same number twice)*:

_____ Family (spouse, children, parents, significant other)

_____ Job (recognition, advancement)

_____ Lifestyle and friends (friends, habits, stress)

_____ Personal finances

_____ Physical condition

_____ Spiritual

List your areas of strength (strong points) as a person:

Please provide any additional information that you believe is important:

Thank you for taking the time to complete this form. It will help us serve you better. If you have other critical documentation related to your concerns, please bring copies of records to your first appointment.