



Adult Patient and Family History

**To be completed by the patient and returned prior to the initial appointment.*
Please attach additional sheet(s) of paper if needed*

I. Patient Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State _____ Zip _____

Home Telephone: () _____ Mobile Telephone () _____

In case of emergency, may we contact you at work? no yes, telephone () _____

II. Developmental History

The following questions refer to your mother's pregnancy with you:

Did she experience any illnesses during the pregnancy? uncertain no yes, explain _____

Did she smoke cigarettes during the pregnancy? uncertain no yes

Did she drink alcohol during pregnancy? uncertain no yes

Did she use any illegal drugs during pregnancy? uncertain no yes, type _____

Were you born premature? uncertain no yes, age at delivery _____

Were there any problems during delivery? uncertain no yes, explain _____

To the best of your knowledge, did you:

Begin walking around the time of your first birthday? uncertain yes no, explain _____

Begin speaking words around the time of your first birthday? uncertain yes no, explain _____

As a child, did you have:

Difficulties with your hearing: uncertain no yes, explain _____

Difficulty with your vision: uncertain no yes, explain _____

III. Mental Health History

Have you previously received mental health care? no (skip to section IV) yes (please describe):

Current or previous psychiatrist? (name, address, telephone, dates of treatment) no yes, _____

Current or previous therapist? (name, address, telephone, dates of treatment) no yes, _____

Previous psychiatric hospitalizations? (where, reason, dates of treatment) no yes, _____

Treatment for alcohol or drug abuse or addiction? no yes, _____

Please list any *previous psychiatric* medications you used:

<i>Name</i>	<i>Dose</i>	<i>Frequency</i>	<i>Date started/stopped</i>	<i>Reason for taking</i>	<i>Reason stopped</i>

IV. Medical History

Your Current Primary Care Physician: _____

Address: _____ City: _____ State _____ Zip _____

Telephone:() _____ Fax () _____

Please list all medications you are currently taking:

<i>Name</i>	<i>Dose</i>	<i>Frequency</i>	<i>Reason</i>	<i>Date started</i>

Please list any allergies you have (including medications, food, environmental):

<i>Item allergic to</i>	<i>Typical reaction</i>	<i>Standard treatment</i>

Please list any ongoing health problems you have (e.g., asthma, diabetes, etc.)

<i>Condition</i>	<i>Treatment</i>	<i>First Diagnosed</i>

Have you ever experienced a head injury (from fall, car accident, sports, etc.) that resulted in loss of consciousness/blackout? no yes, explain _____

Have you ever had surgery? no yes ,explain (when, why)_____

Have you ever been hospitalized overnight? no yes, explain (when, why, duration)_____

Please list any family member(s) with the following illnesses:

<i>Condition</i>	<i>You</i>	<i>Mother</i>	<i>Father</i>	<i>Sibling</i>	<i>Grandparent</i>	<i>Other (who)</i>
Lung Disease (asthma, etc.)						
High Blood Pressure						
Heart Disease						
Gastrointestinal Disease						
Liver Disease						
Kidney Disease						
Diabetes						
Thyroid Disease						
Arthritis						
Cancer (specify type)						
Allergies						
Sexually Transmitted Disease						
AIDS or HIV						
Multiple Sclerosis						
Stroke						
Movement Disorder (Parkinson, etc.)						
Head Injury						
Seizures						
Migraines						
Alzheimer's Disease						
Depression						
Bipolar (Manic-Depression)						
Schizophrenia						
ADHD or ADD						
Obsessive-Compulsive						
Anxiety						
Other:						

V. Employment and School History

Your current Employer: _____

Type of work: _____ Years at this job: _____

School History:

<i>Level of Schooling</i>	<i>Where</i>	<i>Any Concerns/Difficulties</i>
Early Education (0-3 services)		
Elementary School		
Middle School		
High School		
College		
Graduate School		
Other		

While in school, did you ever receive any of the following services? If yes, please describe:

Tutoring: uncertain no yes, explain _____

Special Education: uncertain no yes, explain _____

Physical Therapy: uncertain no yes, explain _____

Occupational Therapy: uncertain no yes, explain _____

Speech Therapy: uncertain no yes, explain _____

Do you have a history of:

Learning disabilities: uncertain no yes, explain _____

Reading problems: uncertain no yes, explain _____

Mathematics problems: uncertain no yes, explain _____

Speech problems: uncertain no yes, explain _____

Coordination problems: uncertain no yes, explain _____

Did your mother have a history of educational difficulties? uncertain no yes, explain _____

Did your father have a history of educational difficulties? uncertain no yes, explain _____

VI. Social History

Are you single, married, cohabitating, divorced, separated, widowed other, _____

Do you have children? no yes, _____

How do you spend your leisure time? _____

What is your religious/spiritual preference, if any? _____

How important is your spiritual life for you and/or your family? _____

Please describe the nature of the problems for which you are seeking treatment: _____

Thank you for completing the form. The doctor will review it with you at your initial appointment.

For office use only
I have reviewed the preceding information with the patient/family.
Signature _____, MD Date: _____