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Adult History Information Form

(If this is for couples therapy, please have each partner fill out a form)

Name _____ **M/F**_____ **Today's Date**_____

Birth Date:_____ **Age:**_____

Name of Person filling out form (if different from above):_____

REASON FOR SEEKING TREATMENT

Please briefly explain your reason for seeking therapy at this time:

Please list any stressors in your life at this time that may contribute to your issues. Some common contributing factors are illness, stressful family relationships, financial stress, career stress, parenting conflicts, death of loved ones or pets, moves, alcohol or drug use, affairs, physical or emotional abuse, legal issues, divorce, friendships, etc.

Please list things you have already tried to solve your issues so far:

MEDICAL INFORMATION

Name of your Primary Care Physician: _____

*Name of Medical Practice*_____

*Address*_____
Street

_____
City, *State,* *Zip Code*

Office Phone # : (___)_____ *Fax # :* (___)_____

May I contact your physician? Please initial: Yes_____ No_____

List any major health problems for which you currently receive treatment:

List any major health problems you have had in the past:

List any medications or supplements with dosages you are currently taking:

Name of Medication	Dosage	Taken how often	What the medication treats

SYMPTOM CHECKLISTS

Following are checklists of a variety of behaviors and symptoms. I would appreciate it if you would take the time to fill these checklists out completely. This information will be extremely useful to me in my completing a more thorough and comprehensive assessment of your issues. It will also enable me to shorten the initial history interview and more quickly develop an individualized treatment plan tailored especially for you. If there are areas you do not feel comfortable answering on paper, just let me know. Please check any of the following items that may pertain to you more often than not or that you have concerns about. Please also feel free to add comments in the spaces.

✔	FEELINGS OF WELL-BEING
	I feel worthwhile
	Respect myself
	Feel close to people
	Care about others
	Feel happy
	My life is satisfying
	Feel I am accomplishing something
	Having fun in life
	Feel hopeful
	My faith plays a part in my life
	The future looks bright
	Believe I can solve my problems
	I have a best friend
	Feel a respect and reverence for life
	Other positive feelings about my life?

✔	SADNESS
	I often feel sad, down, depressed or hopeless
	Little interest or pleasure in doing things
	Poor appetite or overeating – noticeable weight change
	Trouble falling asleep, staying asleep, or sleeping too much
	Feeling often slowed down or sped up
	Frequently feel tired or have little energy
	Often feel excessively worthless or guilty
	Have difficulty concentrating on things or trouble making decisions
	Often have thoughts of wanting to die
	I have a plan for killing or hurting myself in the back of my mind
	Other depression symptoms?

✔	WORRIES
	I have difficulty controlling my worries
	Get tired easily
	Often feel Irritable or crabby
	Muscle tension
	Difficulty falling asleep
	Waking up in the middle of the night
	Waking up in the early morning
	Difficulty concentrating
	Feeling keyed up or restless
	Significant Anxiety
	Worrying about social events
	Worries about looking stupid or being embarrassed
	Difficulty having conversations with others
	Avoid being center of attention
	Other Worries?

✔	PANIC
	I have attacks of sudden intense fear
	Pounding or racing heartbeat
	Shakiness or trembling
	Shortness of breath
	Chest pain
	Nausea or abdominal distress
	Feeling dizzy or lightheaded
	Feeling things are unreal or like a dream
	Fear of losing control or going crazy
	Numbness, tingling, chills, or sweating
	Choking or smothering sensation
	Fear of dying
	Other Panic symptoms?

✔	CONCENTRATION
	I fail to give close attention to details or often make careless mistakes
	Difficulty staying focused on tasks …lectures, conversations, reading
	Often don't seem to listen…mind seems elsewhere
	Don't follow through on instructions …lose focus and am easily sidetracked
	Difficulty organizing tasks and activities …poor time management, messy, etc.
	Procrastinate on projects or tedious jobs …lengthy reports, forms, taxes, etc.
	Often loose things necessary for living …. Keys, cell phone, wallet, paperwork
	Easily distracted by things or events …sometimes by own unrelated thoughts
	Often forgetful in daily activities…returning calls, appointments, bills, errands, etc.

✔	ACTIVITY LEVEL
	I often fidget with hands, taps legs, or restless sitting for long periods
	Often leave seat where remaining seated is expected…office, classroom, etc.
	Feel restless frequently in some situations…lectures, movies, restaurants
	Difficulty doing things quietly or engaging in quiet leisure activities
	Often "On the Go" as if driven by a motor …Others see as hard to keep up with
	Frequently talk excessively
	Often blurt out things…complete other's sentences or "jump the gun" in talking
	Difficulty waiting for my turn…in conversations or while waiting in line
	Frequently interrupt or intrude on others …Conversations, activities, games, etc.

✔	ANGER
	I have trouble controlling anger
	Loose my temper more than I would like
	Drive too fast or too angrily
	Argue with people
	Do things deliberately to annoy people
	Feel like getting back at people
	Sometimes hurt other people or mean
	Often feel angry or resentful
	Often blame others
	Start verbal or physical fights
	Have been arrested or in jail
	Legal charges now or in past
	Throw, break or smash things
	Shouting and yelling more than I'd like
	Other Anger symptoms?

✔	MOOD CHANGES
	My mood changes frequently
	Thoughts go by very fast sometimes
	Sometimes feel I can do almost anything
	Sometimes I do risky things
	Sometimes skip sleeping a night or so
	Get irritated for no reason
	Sometimes feel pressured to keep talking
	Energetic moods
	Buying sprees or Gambling
	Hurt or cut myself
	Mood swings – Up and Down Moods
	Partying too much sometimes
	Sexual indiscretions
	Think of suicide more than I would like
	Other Mood symptoms?

✔	TRAUMATIC EVENTS
	I have experienced a traumatic event
	I have suffered abuse now or in past
	Memories of the event are very upsetting
	I sometimes relive the trauma-flashbacks
	I have nightmares or bad dreams
	Avoid things or feelings about the event
	Can't remember parts of what happened
	I startle easily - often hypervigilant
	Can't stop thinking about the trauma
	Difficulty experiencing pleasure
	Often feel numb inside
	Feel disconnected from others
	Often feel helpless
	Frequently feel guilty or hopeless
	What traumatic events had you had?

✔	TROUBLING THOUGTS
	I worry about going crazy
	Worry others are watching me
	Worry I have thoughts no one else has
	Sometimes have weird experiences
	Worry others often talk about me
	Feel others will take advantage of me
	Something is seriously wrong with me
	I have concerning thoughts about sex
	I sometimes feel I should be punished
	Troubling religious thoughts
	Sometimes I have unspeakable thoughts
	Feel like others control my thoughts
	Hear voices others do not hear
	Feel other people can read my thoughts
	Other troubling thoughts?

✔	OBSESSIONS / COMPULSIONS
	I can't stop thinking about some things
	Can't stop doing some things
	Excessive hand washing
	I Do things too slowly or perfectly
	Excessive checking
	Difficulty making small decisions
	Routines or rituals I can't seem to stop
	Excessive cleaning
	Do things to prevent thoughts / problems
	I know actions are irrational, can't stop
	Needs things to be in order
	Feels I will accidentally hurt others
	Avoid things because of obsessions
	Have some sexual compulsions
	Other specific obsessions / compulsions?

✔	HEALTH CONCERNS
	I am concerned about my health
	Stomachaches
	Headaches
	Pains in heart or chest
	Backaches
	Sore muscles
	Dizziness
	Fear of having a serious disease
	Frequent doctor visits
	Chronic pain or unexplained pain
	Feeling weak or often tired
	Fear of death
	Any Chronic Illnesses?
	Specific health Concerns at this time?

✔	PERSONAL RELATIONSHIPS (With family, friends, co-workers)
	I struggle with healthy relationships
	Often feel lonely
	Frequently disappointed by relationships
	Often don't feel close to others
	Lots of conflict in relationships
	Have few friends
	Often feel critical of others
	Feel others dislike me
	Feel inferior to others frequently
	Often self-conscious
	Extremely shy
	Too sensitive
	Feel most people cannot be trusted
	Don't feel close to anybody
	Other concerns?

✔	PARTNER RELATIONSHIPS (Fill out if you are in a Partnership)
	We don't have enough closeness
	Verbal fighting
	Trouble with finances
	Difficulty dividing chores
	Sexual concerns in our relationship
	Affair or emotional Betrayals
	Trust or jealousy issues
	Physical fighting
	Communication problems
	Religious differences
	Feeling emotionally distant or apart
	Parenting conflicts
	Difficulties with in-laws or relatives
	Trouble having fun together
	Other concerns about your partnership?

✔	BAD HABITS
	Smoking too much
	Drinking too much
	Gambling more than I would like
	Taking pain killers too much
	Taking too many prescription drugs
	Taking other substances I don't like
	Not motivated to get things done
	Drug use
	Sexual Indiscretions
	Buying sprees
	Driving recklessly or too fast
	Chewing tobacco too much
	Other?

✔	DAILY FUNCTIONING
	I have trouble sleeping
	I can't get to sleep at night often
	I wake up in the middle of the night often
	I wake up early in the morning
	I take long naps during the day
	I overeat
	I eat when I am emotional
	Sometimes I don't care to eat
	I don't exercise regularly
	I would like to exercise more
	I exercise too much
	I binge eat or throw up sometimes
	I don't have energy
	I often have constipation or diarrhea
	Other problems?

FAMILY HISTORY – Please check any of the following conditions that your biological relatives may have experienced:

	Depression		Hyperactivity (ADHD)		Alcohol Problems
	Anxiety		Bipolar Disorder		Drug Problems
	Mood Swings		Attempted Suicide		Completed Suicide
	Panic Attacks		Obsessive-Compulsive Dis		Tic Disorder
	Learning Disabilities		Problems with the Law		Jail time
	Heart Disease		Diabetes		Obesity
	High Blood Pressure		Cancer		Thyroid Problems
	Physical Abuse		Emotional Abuse		Neglect
	Sexual Abuse		Seizures		Schizophrenia
	Other:				

Please list any mental health treatment you have had in the past including therapists, psychologists, psychiatrists, psychiatric hospitalizations, substance abuse treatment, etc.

Please list your strengths or what you are really good at:

Please list your favorite activities / hobbies / ways you relax:

What are you most looking forward to?

Thank you very much for your patience in taking the time to answer all of these questions about yourself and your family. It really helps me do a more comprehensive evaluation for you. If you have any questions at all about this questionnaire, please feel free to bring it up with me.

Thank You!