

PSYCHOLOGY HEALTH GROUP
A Group of Independent Practitioners
ADULT PATIENT HISTORY

Name _____ Date _____
Referred by _____

I. Identifying Information:

Date of birth _____ Age _____
Home phone _____ Sex _____
Work phone _____ Spouse's name _____
Marital status _____ Number of marriages _____ Present marriages (years) _____
Living arrangements _____
Race/ethnic group _____

Children _____	Age _____	in home	Y	N
_____	Age _____	in home	Y	N
_____	Age _____	in home	Y	N
_____	Age _____	in home	Y	N
_____	Age _____	in home	Y	N
_____	Age _____	in home	Y	N

Education _____
Occupation _____ Number hours worked per week _____
Spouse's education _____
Spouse's occupation _____ Number hours worked per week _____

Work history:

Organization _____	Position _____	Years _____
Organization _____	Position _____	Years _____
Organization _____	Position _____	Years _____
Organization _____	Position _____	Years _____

Have you ever been on workmen's compensation or any other disability income? Y N
Are there any disability claims/applications pending now? Y N

Military History Y N

If yes, please branch _____
Highest rank _____
Type of discharge _____

II. Presenting problem or areas of needed improvement:

- A. Specific problems or symptoms that prompted you to call Psychology Health Group

- B. When did you first become aware of these problems/symptoms? _____

- C. Specific stressors in your life _____

Name _____

III. Symptoms checklist for the last three months:

Any change in sleeping pattern
If yes, since when _____
What time do you go to sleep? _____
What time do you get up? _____
How often do you wake up in the middle of the night? _____
What wakes you up? _____

	Yes	Sometimes	No
Difficulty getting to sleep -----	_____	_____	_____
Waking up in the middle of the night -----	_____	_____	_____
Waking too early -----	_____	_____	_____
Nightmares -----	_____	_____	_____
Feeling depressed most of the day -----	_____	_____	_____
Crying spells -----	_____	_____	_____
If yes, how often _____			
Feeling irritable and restless -----	_____	_____	_____
Easily frustrated -----	_____	_____	_____
Loss or gain of weight or appetite change -----	_____	_____	_____
Please specify _____			
Change of energy level -----	_____	_____	_____
Please describe _____			
Thoughts going too fast -----	_____	_____	_____
Forgetfulness -----	_____	_____	_____
Dislike of one's body -----	_____	_____	_____
A lack of confidence -----	_____	_____	_____
Moodiness -----	_____	_____	_____
Loss of motivation -----	_____	_____	_____
Diminished pleasure -----	_____	_____	_____
Feelings of hopelessness -----	_____	_____	_____
Feelings of guilt or worthlessness -----	_____	_____	_____
Diminished ability to think or concentrate -----	_____	_____	_____
Indecision -----	_____	_____	_____
Recurrent thoughts of death or suicide -----	_____	_____	_____
How often _____			
When was the first time _____			
Suicidal plans -----	_____	_____	_____
Previous suicidal actions -----	_____	_____	_____
Hearing voices outside your head -----	_____	_____	_____
Hearing voiced inside your head -----	_____	_____	_____
Feeling a need t do odd or repetitive things, such as:			
Counting things for no reason -----	_____	_____	_____
Checking locks, alarms, the stove, etc -----	_____	_____	_____
Obsessive cleanliness -----	_____	_____	_____
Excessive hand washing or bathing -----	_____	_____	_____
Plucking hair -----	_____	_____	_____
Making lists -----	_____	_____	_____

Name _____

	Yes	Sometime	No
Needing things to be perfect, symmetrical, or evenly spaced -----	_____	_____	_____
Hearing a voice call your name or yelling at you -----	_____	_____	_____
Hearing a voice telling you are bad or telling you to hurt yourself -----	_____	_____	_____
Seeing things that other people don't see, including distorted images ---	_____	_____	_____
Strange tastes or smells or other peculiar sensations -----	_____	_____	_____
Frightening thoughts -----	_____	_____	_____
Unusual beliefs -----	_____	_____	_____
Ideas that seem odd or out of touch with reality -----	_____	_____	_____
Thinking the TV or radio is speaking to you -----	_____	_____	_____
Thinking that someone is out to harm you when it is not really the case --	_____	_____	_____
Believing that you have special powers or that you are cursed -----	_____	_____	_____
Sensory experiences that you cannot explain:			
Visual -----	_____	_____	_____
Hearing -----	_____	_____	_____
Taste -----	_____	_____	_____
Body sensations -----	_____	_____	_____
Feeling suspicious and distrustful of others -----	_____	_____	_____
Preference of being alone and not enjoying close relationships with others	_____	_____	_____
Beliefs or ideas that others find unusual or odd -----	_____	_____	_____

Have you ever felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? _____	_____	_____	_____
Have you ever been so irritable that you shouted at people or started arguments or fights? -----	_____	_____	_____
Have you ever felt much more self-confident than usual? -----	_____	_____	_____
Have you ever gotten much less sleep than usual and found you really didn't miss it? -----	_____	_____	_____
Have you ever been much more talkative or spoke much fast than usual?-	_____	_____	_____
Have thoughts raced through your head or you couldn't slow or you couldn't slow your mind down?-----	_____	_____	_____
Have you ever been so easily distracted by things around you that you had trouble concentrating or staying on track? -----	_____	_____	_____
Have you ever had much more energy than usual? -----	_____	_____	_____
Have you ever been much more active or did many more things than usual? -----	_____	_____	_____
Have you ever been much more social or outgoing than usual? (For example, you telephoned friends in the idle of the night) --	_____	_____	_____
Have you ever been much more interested in sex than usual? -----	_____	_____	_____
Have you ever done things that were unusual for you or that other people might have thought were excessive, foolish, or risky? -----	_____	_____	_____
Has spending money ever gotten you or your family into trouble? -----	_____	_____	_____
If you check YES to ore than one of the above, have several of these ever happened at the same time? -----	_____	_____	_____

How much did these problems below the above black line cause you to be unable to work, have family, money, or legal troubles or get into arguments or fights?

(Please circle one response only)

No problem Minor problem Moderate problem Serious problem

Name _____

	Yes	Sometimes	No
Have any of your blood relatives (i.e. children, siblings, parents, grand- parents, aunts, uncles) had manic-depression illness or bipolar disorder? --	_____	_____	_____
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? -----	_____	_____	_____
Scared to death or as if you are losing your mind -----	_____	_____	_____
Shortness of breath -----	_____	_____	_____
Smothering sensation -----	_____	_____	_____
Accelerated heart rate -----	_____	_____	_____
Trembling or shaking -----	_____	_____	_____
Sweating or choking -----	_____	_____	_____
Nausea or abdominal distress -----	_____	_____	_____
Feeling like you or the world is not real -----	_____	_____	_____
Numbness or tingling -----	_____	_____	_____
Hot flashes or chills -----	_____	_____	_____
Chest discomfort -----	_____	_____	_____
Out of body experience -----	_____	_____	_____
Fear of dying -----	_____	_____	_____
Fear of going crazy -----	_____	_____	_____
Excessive worrying -----	_____	_____	_____
Dizziness -----	_____	_____	_____
Fear of doing something uncontrolled -----	_____	_____	_____
Fear of being in places where escape might be difficult or getting help would be difficult -----	_____	_____	_____
Fear of leaving home or being in your "safety zone" -----	_____	_____	_____
Fear of one or more situations -----	_____	_____	_____
Avoidance of one or more situations -----	_____	_____	_____
Repetitious acts or thoughts -----	_____	_____	_____
Strange thoughts that intrude on your mind -----	_____	_____	_____
Daily muscular tension -----	_____	_____	_____
Poor memory from early childhood -----	_____	_____	_____
A sense of not being yourself -----	_____	_____	_____
An inability to control pain -----	_____	_____	_____
Uncontrolled pain -----	_____	_____	_____
On a scale of 0-10 with 0 representing no pain and 10 representing the worst possible pain, what is your pain level most days	_____		
Staring off into space, thinking of nothing, and losing awareness of the passage of time -----	_____	_____	_____
Severe and frequent headaches -----	_____	_____	_____
An inability to tell people how you feel and what you need -----	_____	_____	_____
Impulses that you cannot control -----	_____	_____	_____
Any worrisome eating or weight loss behavior -----	_____	_____	_____
Making yourself throw up -----	_____	_____	_____
Going without food for extended periods of time -----	_____	_____	_____

Name _____

	Yes	Sometimes	No
Use of diet pills -----	_____	_____	_____
Use of laxatives -----	_____	_____	_____
Binge eating -----	_____	_____	_____
Exhaustive exercising -----	_____	_____	_____
Worrying about appearance that interferes with work or socializing ---	_____	_____	_____
Inattention -----	_____	_____	_____
Distractibility -----	_____	_____	_____
Failure to finish tasks -----	_____	_____	_____
Difficulties with the law -----	_____	_____	_____
Mood fluctuations between depression, anxiety or anger -----	_____	_____	_____
Self damaging acts (reckless driving, self-mutilation ,etc.) -----	_____	_____	_____
Tendency to be shy or nervous around others -----	_____	_____	_____
Inflated sense of self-importance and an intense need for admiration -	_____	_____	_____
Tendency to be shy or nervous around others -----	_____	_____	_____
Tendency to be overly dependent on others and to need an excessive	_____	_____	_____
amount of reassurance form others -----	_____	_____	_____
Tendency to be excessively preoccupied with neatness, rules,	_____	_____	_____
details, etc.-----	_____	_____	_____
Have you ever been abused as a child or an adult?			
Sexually -----	_____	_____	_____
Physically -----	_____	_____	_____
Emotionally -----	_____	_____	_____
Have you experience a psychologically distressing event that is			
outside the range of usual human experience?-----	_____	_____	_____
If yes, please describe: _____			

Do you ever re-experience the abuse or unusual experience? -----	_____	_____	_____
Have you had recurrent, intrusive recollections ? -----	_____	_____	_____
Have you had recurrent dreams? -----	_____	_____	_____
Have you acted or felt as if the event were occurring? -----	_____	_____	_____
Have you ever seen a number of physicians for a physical problem			
that they have had difficulty diagnosing or treating? -----	_____	_____	_____
If yes, please describe: _____			

Do you have more than your share of illnesses or injuries? -----	_____	_____	_____
Have you ever been physically violent? -----	_____	_____	_____
Have you ever been arrested? -----	_____	_____	_____
If yes, please explain: _____			

Are you presently involved in or have you ever been involved			
in a lawsuit?-----	_____	_____	_____
If yes, please explain: _____			

Name _____

Yes No

III: Past Mental Health History

Have you ever been hospitalized for psychiatric or substance abuse problems? -- _____
If so, how many times, where and at what age _____

Have you taken any medications to treat psychiatric disorders? ----- _____

Name medication	Prescribing Doctor	Approximate date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any counseling or psychotherapy?

Problem	Therapist	Appropriate date	Result of treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever inflicted pain or harm on yourself?

If so, when and for what purpose _____

IV: Medical History

A. Please list all current physicians, where they work, and what they are treating you for.

Current physician	Location	Medical Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____

How long has it been since your last physical examination, blood tests? _____

How old were you when you started menstruating (women)? _____

B. Current prescription and medications and dosage, supplements, and herbal remedies

C. Prescription medications recently discontinued _____

D. Allergies and/or drug reactions _____

E. Hospitalizations (date and reason) _____

F. Present health problems _____

Name _____

G. SUBSTANCE USE (please check appropriate boxes)

	Yes	No	Past	Present	Frequency
Alcohol	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____
Cigarettes	_____	_____	_____	_____	_____
Over the counter drugs (frequency and type)	_____				

List any other drug use in the last year (including street drugs) _____

H. Developmental History

To the best of your knowledge, did any of the following prenatal, labor and delivery, or childhood problems occur during your lifetime:

	Yes	No
Illness of mother during pregnancy -----	_____	_____
Medications or drugs taken by mother during pregnancy -----	_____	_____
Mother's age at birth of child was over 35 -----	_____	_____
Abnormal length of or difficulty with labor (longer than 8-10 hours) -----	_____	_____
Forceps delivery -----	_____	_____
Caesarean section delivery -----	_____	_____
Possible anoxia in child during delivery -----	_____	_____
High fevers during childhood -----	_____	_____
Childhood convulsions -----	_____	_____
Childhood fainting spells -----	_____	_____
Childhood illnesses -----	_____	_____
Delay in learning to walk -----	_____	_____
Delay in learning to talk -----	_____	_____
Delay in toilet training -----	_____	_____
School difficulties in learning -----	_____	_____
Behavior problems in school or at home -----	_____	_____
Repeated grades -----	_____	_____
Special education -----	_____	_____

I. General Health

Any significant injuries -----	_____	_____
Head injuries -----	_____	_____
Visual problems -----	_____	_____
Hearing problems -----	_____	_____
Blackouts -----	_____	_____
Memory problems -----	_____	_____
Onset of memory problems _____	_____	_____
Language disturbances -----	_____	_____

Name _____

Disturbance in coordination or gait -----
Episodes of uncontrolled behavior in the absence of provocation -----
High blood pressure -----
Heart disease -----
Lung disease -----

	Yes	No
Asthma or allergies -----	<input type="checkbox"/>	<input type="checkbox"/>
Cancer -----	<input type="checkbox"/>	<input type="checkbox"/>
Blood sugars too high or too low -----	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma -----	<input type="checkbox"/>	<input type="checkbox"/>
Seizures -----	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease -----	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease -----	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease -----	<input type="checkbox"/>	<input type="checkbox"/>
Male/Female problems -----	<input type="checkbox"/>	<input type="checkbox"/>

V. Family History

A. Mother's name _____ Age _____
Father's name _____ Age _____

List of siblings in order, oldest to youngest, with their ages

B. Please list any significant medical illnesses among blood relatives and who had what illness ____

C. Is there any history of psychological problems in your family of origin? (anxiety, depression, mood swings, erratic behavior, schizophrenia, ADHD, etc) _____ Yes _____ No
If yes, please list their name and relation to you along with their problem _____

Has anyone in your family of origin received mental health treatment or hospitalization for emotional problems? _____ Yes _____ No

If yes, please list their name and relation to you along with their problem _____

D. Is there any history of alcohol or substance abuse in your family or origin (parents or siblings)? _____ Yes _____ No

If yes, please list their name and relation to you _____

Has anyone in your family of origin received treatment for alcohol or substance abuse? _____ Yes _____ No

If yes, please list their name and relation to you _____

E. If you have grandchildren, how many do you have? _____

How often do you see them? _____

Name _____

VI. Marital and Relationship History

Spouse/Partner's Age: _____ Spouse/Partner's occupation: _____
Spouse/Partner's personality (In your own words): _____

Check areas where problems exist:

Children _____ Finances _____ Religious differences _____ In-laws _____ Communication _____
Arguments _____ Friends _____ Substance Abuse _____ Physical abuse _____ Sex _____ Work _____
Verbal abuse _____ Affairs _____ Recreation/leisure _____ Emotional abuse _____ Other: _____

How do you get along with your in-laws? (including brothers and sisters-in-law):

Give details of any previous marriages or long-term relationships:

Please list family members who you believe are supportive of you or who you can trust to help you when you are in a crisis: _____

Please list friends or social groups who you believe would be supportive of you or who you can trust to help you when in a crisis: _____

Thank you for your time and patience in completing this questionnaire. Please present this history form to the receptionist for the clinician to review prior to your appointment.

All the answers and information contained in this history form are accurate to my knowledge. Any question or request for information left blank was done intentionally. I may not know the answer or I wish not to reveal this information at this time.

Signature _____ Date _____