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Phone: 414-716-6335

Client Name: _____

Date of Birth: _____

AGE: _____

Adult Personal Health History Form

(Please Print Clearly)

INSTRUCTIONS: Please answer the following questions. This will help to better understand your situation.

PERSONAL HEALTH HISTORY

Please describe your reason for this appointment: _____

_____

When did the problem(s) begin? _____

Has the problem been constant since it's beginning? ○ Yes ○ No If No, Describe _____

Is the problem ever absent? ○ Yes ○ No If Yes, when? _____

Members of your Family, Including your Spouse/Partner/Significant Other:

Name	Age	Occupation/ School	Relationship	Lives With

Educational History (Highest Grade Completed): _____

Social Activities: Please describe your exercise and leisure/recreational activities and other interests: _____

_____

Presently Employed? ○ Yes ○ No Place of Employment: _____
Position: _____How Long?: _____

Military Service: ○ Yes ○ No **Branch/Rank/Dates:** _____ Deployment(s): _____
Honorable Discharge: ○ Yes ○ No If No, Describe:_____

Financial Problems: ○ Yes ○ No If Yes, Describe: _____

Legal Problems: ○ Yes ○ No If Yes, Describe: _____

Spirituality: Do you have a religious/spiritual preference? ○ Yes ○ No If Yes, Describe: _____
How important is your religion/spirituality in your life? _____
Are you actively involved in any religious/spiritual organization? ○ Yes ○ No If Yes, Describe: _____

Cultural: Are there any cultural/ethnic expectations, values or pressures causing conflict in your life your therapist should be aware of? ○ Yes ○ No If Yes, Describe: _____

CURRENT AND PAST MEDICAL HISTORY

Name of your Primary Care Physician (PCP): _____ **Phone:** _____
Address of PCP: _____

Have you had a medical exam or physical within the last year? ○ Yes ○ No If Yes, Date: _____

List ALL Current Medical Conditions or Disabilities: _____
_____

List of ALL Current Medications & Dose (Include non-prescription): _____
_____
_____

List any Past Medical Conditions (Include Surgeries): _____
_____

List All Previous Mental Health Services Received:

With Whom? Name and Location	Year	How Long?	For What?	Outpatient or Inpatient?

Are you currently under the care of a doctor/physician for emotional conditions? ○ Yes ○ No If Yes, Please describe the emotional condition, provider name, address, phone number and date last seen: _____
_____

Are there any medical and/or physical or emotional problems in the family that concern you? ○ Yes ○ No If Yes, Describe:
_____

Drug and Alcohol Use – Please describe the drug and alcohol use of your family. Use the number which best describes how often each person uses each drug. 0=Never, 1=less than once a month, 2=1-4 days a month, 3= almost daily, 4=daily, 5=used in the past, not using now

Substance	Self	Spouse/Partner	Child	Child	Your Parents
Caffeine	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____
Beer/Wine/Liquor	_____	_____	_____	_____	_____
LSD	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____
Sedatives	_____	_____	_____	_____	_____
Amphetamines	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____
Other (specify)	_____	_____	_____	_____	_____

Have you ever thought about cutting down on your drug or alcohol use? ○ Yes ○ No
Do you get annoyed when people ask you about your use of drugs or alcohol? ○ Yes ○ No
Do you ever feel guilty about your use of drugs or alcohol? ○ Yes ○ No
Do you ever drink or use drugs in the morning? ○ Yes ○ No
Are you concerned about the alcohol or drug use of someone in your family? ○ Yes ○ No

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____