Adult Health History

(Patient to complete this document before session.)

Today's date: _____

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Person completing this form: _____ **Relationship to patient:** _____

Gender: ☐ Female ☐ Male ☐ Transgender **Who referred you?** _____

Ethnicity: ☐ Asian ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Other _____

Marital Status: (circle one)
married
separated
divorced
widowed
partnered
never married

Education: (circle highest level)
completed grade: 1 2 3 4 5 6 7 8 9 10 11 12 GED
years of college: 1 2 3 4
graduate degree: Master's Doctoral _____

Children? ☐ Yes ☐ No **If yes, how many?** _____

How happy are you with how you read in English? ☐ Very happy ☐ Ok ☐ Not very happy

What problem(s) are you seeking help for? _____

_____

When did these problems start? _____

Why are you seeking help now? _____

_____

Which services are you looking for?

Counseling or psychotherapy: ☐ Yes ☐ No

Psychiatric medication: ☐ Yes ☐ No

Psychological testing: ☐ Yes ☐ No

Do you have any of these medical problems?

Heart Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Lung - COPD/asthma	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Immune System	☐ Yes	☐ No	Diagnosed COVID-19	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Dry cough	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Neurological Disorder	☐ Yes	☐ No	Fever	☐ Yes	☐ No

Do you have any other medical problems? _____

_____

Do you have any allergies to medications? _____

Who is your primary care doctor? _____

Do you see any specialist doctors? _____

FOR WOMEN ONLY: Are you currently pregnant or trying to get pregnant? ☐ Yes ☐ No

Have you had any problems with menstruation, pregnancy or childbirth? ☐ Yes ☐ No

If yes, describe: _____

Did you ever have a concussion or head injury? ☐ Yes ☐ No If yes, describe: _____

_____

Were you ever diagnosed with a psychological disorder? ☐ Yes ☐ No

If yes, which one(s)? _____

If yes, how long ago? _____

Have you ever been in counseling before? ☐ Yes ☐ No

When was it? _____

Who did you see? _____

Did it help? How? _____

Have you ever seen a psychiatrist? ☐ Yes ☐ No If yes, for what? _____

_____

Have you ever had personality testing, IQ testing, or neuropsychological testing? ☐ Yes ☐ No

If yes, please describe: _____

Did you have any learning problems in school? ☐ Yes ☐ No If yes, describe: _____

_____

Have you had any losses or traumas in your life? ☐ Yes ☐ No If yes, describe: _____

_____

Have you ever been in a psychiatric hospital? ☐ Yes ☐ No If yes, describe: _____

_____

Have any of your family members been diagnosed or treated for a psychiatric problem?

Family Member	Type of Psychiatric Problem

Where were you born and raised? _____

Who raised you? _____

Were there any drug or alcohol problems in your childhood home? _____

If yes, describe: _____

Was there violence in your childhood home? ☐ Yes ☐ No If yes, describe: _____

_____

Was there any abuse towards you? ☐ None ☐ Physical ☐ Sexual ☐ Verbal ☐ Emotional

Were you ever in the military? ☐ Yes ☐ No When? _____

Who do you live with now? _____

_____

How stressful are your finances? _____

Were you ever convicted of a crime? ☐ Yes ☐ No If yes, please describe: _____

_____

Have you had any other legal problems? (example: bankruptcy, being sued, etc) ☐ Yes ☐ No

If yes, describe: _____

Are you part of a religious/spiritual group? ☐ Yes ☐ No Which one? _____

Are you: employed / unemployed / disabled / retired **What job do you have?** (if any) _____

What jobs did you have in the past? _____

What do you normally do for enjoyment or fun? _____

COVID-19 Stressors (please check "yes" or "no")**:**

1. Did you have COVID-19, now or in the past? ☐ Yes ☐ No
2. Did you have exposure to a person or place with COVID-19 that worries you? ☐ Yes ☐ No
3. In 2020, have you travelled to COVID-19 hot-spot areas in the US or abroad? ☐ Yes ☐ No
4. Do you have friends or family members with COVID-19? ☐ Yes ☐ No
   a. Are they in the hospital? ☐ Yes ☐ No
   b. Are they in the ICU or on a ventilator? ☐ Yes ☐ No
   c. Have they passed away from COVID-19? ☐ Yes ☐ No
5. Are you currently able to work? ☐ Yes ☐ No
   a. Are you working from home? ☐ Yes ☐ No
   b. Has your job been reduced, downsized, or furloughed? ☐ Yes ☐ No
   c. Have you recently lost your job? ☐ Yes ☐ No
   d. Is your spouse/partner working from home? ☐ Yes ☐ No ☐ N/A
   e. Did your spouse/partner lose their job, or has it been downsized? ☐ Yes ☐ No ☐ N/A
6. Do you have other concerns or problems with your partner/spouse or family? ☐ Yes ☐ No
7. If you have children, are they out of school? ☐ Yes ☐ No ☐ N/A
   a. If so, are you trying to homeschool them? ☐ Yes ☐ No ☐ N/A
   b. Do you have any parenting concerns? ☐ Yes ☐ No ☐ N/A

Is there anything else you want your psychologist to know? _____

_____

_____

_____

Reviewed by psychologist: _____ Date: _____