PSYCHOLOGY HEALTH GROUP
A Group of Independent Practitioners
ADULT PATIENT HISTORY

Name _____ Date_____
Referred by _____

I**. Identifying Information**:

Date of birth _____ Age _____
Home/Cell phone _____Gender _____
Work phone _____
Spouse/Significant Other/Partner'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/ Significant Other/Partner's education _____
Spouse/ Partner/ SO'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 ----------	____	_____	___
Severs 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 ----------	_____	_____
Cancer ----------	_____	_____
Blood sugars too high or too low ----------	_____	_____
Glaucoma ----------	_____	_____
Seizures ----------	_____	_____
Kidney disease ----------	_____	_____
Liver disease ----------	_____	_____
Thyroid disease ----------	_____	_____
Male/Female problems ----------	_____	_____

V. **Family History**

A. Parent's name _____ Age ____
Parent'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/ Significant Other/Partner's Age: _____
Spouse/ Significant Other/Partner's occupation: _____
Spouse/ Significant Other/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_____