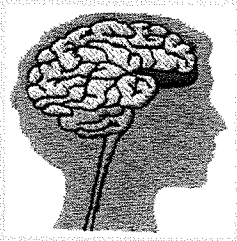

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ADULT HISTORY FORM

(Revised 12-2018) **DATE:** _____

FIRST NAME: _____ **LAST NAME:** _____

MIDDLE INITIAL: _____ **PREVIOUS NAME:** _____

IF P.O. BOX, YOU MUST PROVIDE A PHYSICAL ADDRESS. CURRENT WEIGHT: _____

ADDRESS: _____ **HOME #:** _____

_____ **MOBILE #:** _____

_____ **E-MAIL:** _____

BIRTHDATE: _____ **CURRENT AGE:** _____ **SEX:** _____

SOCIAL SECURITY #: _____ **ARE YOU RIGHT OR LEFT HANDED?**

DRIVER'S LICENSE NUMBER: _____ **STATE ISSUED:** ____

IF YOU HAVE A LEGALLY APPOINTED GUARDIAN PLEASE PROVIDE:

GUARDIAN'S FULL NAME: _____

ADDRESS: _____ HOME #: _____

_____ MOBILE #: _____

_____ E-MAIL: _____

WHY HAVE YOU BEEN REFERRED TO OUR PRACTICE?: _____

WHO REFERRED YOU TO OUR PRACTICE?: _____

ADDRESS: _____ **PHONE #:** _____

_____ **FAX #:** _____

_____ **E-MAIL:** _____

FAMILY DOCTOR: _____

ADDRESS: _____ **PHONE #:** _____

_____ **FAX #:** _____

_____ **E-MAIL:** _____

IF YOU ARE SEEING ANY OTHER DOCTORS, PLEASE LIST THEM ON ANOTHER PAGE. BE SURE TO INCLUDE THE ADD ADDRE ADDRESS, PHONE #, FAX #, AND E-MAIL ADDRESS.

MEDICAL HISTORY

BRIEFLY DESCRIBE YOUR CURRENT MEDICAL PROBLEM(S), CONDITION(S) AND DIAGNOSES:

_____

_____

_____

_____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (PLEASE CIRCLE)

High Blood Pressure
Chronic Pain/Chronic Headaches
Heart Disease
Lung Disease
Thyroid Disease
Kidney Disease
Liver Disease
Exposure to Harmful Chemicals/Gases or Other Poisons

Diabetes/Hypoglycemia
Skin Problems
Anemia/Blood Disorders
Cancer
Rheumatoid Disorders
Sexually Transmitted Disease
HIV Infection or AIDS
Ulcer/Colitis/Gastritis/Irritable Bowel

Loss of Consciousness
Head Injury
Seizures
Stroke

Encephalitis
Meningitis
Serious Accident/Injury

Significant Depression
Severe Anxiety
Thoughts of Suicide
Chronic Fatigue

Physical/Sexual Abuse
Eating Disorder
Sleep Disorder
Sexual Dysfunction

Marital Problems
Counseling
Psychiatric Hospitalization

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR FOODS? (Please List)

_____

_____

_____

IF YOU HAVE EVER BEEN HOSPITALIZED OR HAD SURGERY PLEASE STATE:

REASON: _____

WHEN: _____ **WHERE:** _____

IF HOSPITALIZED MORE THAN ONCE, LIST ALL REASONS, WHEN AND WHERE ON ANOTHER PAGE.

IF YOU HAVE EVER HAD A PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL EVALUATION BEFORE PLEASE STATE.

DOCTOR'S NAME: _____

WHEN: _____ WHERE: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER, HERBAL, AND VITAMIN/MINERAL/DIETARY SUPPLEMENTS (BRING ALL MEDICATIONS THAT YOU MAY NEED DURING THE APPOINTMENT WITH YOU):

MEDICATION NAME **DOSAGE (INCLUDE STRENGTH AND FREQUENCY)**

_____

_____

_____

_____

_____

_____

_____

HAVE YOU EVER BEEN IN COUNSELING? (PLEASE CIRCLE) YES NO

IF YES, PLEASE STATE REASON(S) AND LOCATION WHERE COUNSELING WAS RECEIVED: _____

_____

ADDRESS: _____ PHONE #: _____

_____ FAX #: _____

_____ E-MAIL: _____

DO YOU NOW OR HAVE YOU PREVIOUSLY USED ALCOHOL? (PLEASE CIRCLE) YES NO

AT WHICH AGE DID YOU BEGIN DRINKING?: _____

WHAT DO YOU DRINK? (e.g. BEER, WINE, LIQUOR):_____

HOW FREQUENTLY DO YOU DRINK? (PLEASE CIRCLE)

Daily Once a week More than once a week Once every two weeks Less than every two weeks Rarely

AT THE TIME OF YOUR LIFE THAT YOU DRANK MOST HEAVILY, HOW MUCH WERE YOU DRINKING?

_____

HAVE YOU EVER HAD PROBLEMS WITH YOUR HEALTH, JOB, MARRIAGE, FAMILY, FINANCES OR LEGAL PROBLEMS DUE TO YOUR ALCOHOL USE? (IF YES, PLEASE EXPLAIN): _____

_____

DO YOU NOW OR HAVE YOU PREVIOUSLY USED STREET DRUGS? (IF YES, PLEASE EXPLAIN):

_____

DO YOU SMOKE? (IF YES, WHEN DID YOU START AND HOW MUCH DO YOU SMOKE NOW):

_____

EDUCATIONAL HISTORY

YEARS OF EDUCATION (PLEASE CIRCLE): **Some High School** (# of years _____)

GED High School Associate's Degree Bachelor's Degree Master's Degree Doctoral Degree

HIGH SCHOOL: _____

CITY/STATE: _____ LAST YEAR ATTENDED: _____

COLLEGE/UNIVERSITY: _____

CITY/STATE: _____ LAST YEAR ATTENDED: _____

IF YOU GRADUATED FROM HIGH SCHOOL, PLEASE INDICATE YOUR GRADE AVERAGE (GPA):

_____

IF YOU GRADUATED FROM COLLEGE/GRADUATE SCHOOL, WHAT WAS YOUR MAJOR?:

_____

HAVE YOU EVER BEEN INFORMED THAT YOU HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE):

Learning Disability Attention Deficit Disorder Hyperactivity Behavioral Problems

Autism Asperger's Syndrome Fetal Alcohol Syndrome

WERE YOU EVER HELD BACK A GRADE IN SCHOOL? (PLEASE CIRCLE): YES NO

WHAT GRADE?: _____

OCCUPATIONAL HISTORY

ARE YOU CURRENTLY EMPLOYED? (PLEASE CIRCLE): YES NO

IF YES, EMPLOYER: _____ HOW LONG?: _____

ADDRESS: _____ PHONE #: _____

_____ FAX #: _____

_____ E-MAIL: _____

POSITION: _____

_____

WHERE WAS YOUR PREVIOUS EMPLOYMENT? (OR IF RETIRED WHAT WAS YOUR PRIMARY OCCUPATION?)

NAME: _____ HOW LONG?: _____

_____ PHONE #: _____

_____ FAX #: _____

SOCIAL HISTORY

CURRENT MARITAL STATUS: (PLEASE CIRCLE): Single Married Separated Divorced Widowed

HOW LONG HAVE YOU BEEN/WERE YOU MARRIED?: _____

CURRENT SPOUSE'S NAME: _____

HOW MANY TIMES HAVE YOU BEEN MARRIED?: _____

HOW MANY CHILDREN DO YOU HAVE? (INCLUDE NAME, AGE AND SEX):

_____

_____

_____

_____

PLEASE DESCRIBE YOUR CURRENT LIVING SITUATION (WHO YOU LIVE WITH, ETC.):

_____

WHAT DO YOU DO FOR RELAXATION, LEISURE OR HOBBIES?:

_____

ARE YOU CURRENTLY EXPERIENCING STRESS DUE TO FAMILY PROBLEMS, WORK RELATED PROBLEMS, FINANCES, TRAUMATIC EVENTS, OR OTHER CAUSES? (PLEASE DESCRIBE):

_____

_____

HAVE YOU EVER BEEN ARRESTED? (PLEASE EXPLAIN):

_____

_____

ARE YOU CURRENTLY INVOLVED IN A LAWSUIT, CRIMINAL MATTER OR OTHER LEGAL PROCEEDING? (PLEASE EXPLAIN): _____

_____

_____

ATTORNEY'S NAME: _____

ADDRESS: _____ PHONE #: _____

_____ FAX #:_____

_____ E-MAIL: _____

DO YOU HAVE A CASE MANAGER? (PLEASE CIRCLE): YES NO

CASE MANAGER'S NAME: _____

ADDRESS: _____ PHONE #: _____

_____ FAX #: _____

_____ E-MAIL: _____

IS THERE ANYTHING ELSE YOU WISH THE DOCTOR TO KNOW ABOUT YOUR PHYSICAL OR PSYCHOLOGICAL HEALTH HISTORY?: _____

_____

_____

_____

_____

IN CASE OF AN EMERGENCY, WHO WOULD YOU LIKE US TO CONTACT?

NAME: _____ RELATIONSHIP TO YOU: _____

ADDRESS: _____ HOME #: _____

_____ MOBILE #: _____

_____ E-MAIL: _____

NEAREST RELATIVE **NOT** LIVING WITH YOU:

NAME: _____ RELATIONSHIP TO YOU: _____

ADDRESS: _____ HOME #: _____

_____ MOBILE #: _____

_____ E-MAIL: _____