



Patient Name: _____ DOB _____

Adult Patient History Form

Allergies: _____

Current and previous medical history: _____

Surgical procedures and dates: _____

Mental health hospitalizations (include year and reason): _____

Family psychiatric history (list any family member with mental health issues- depression, anxiety, etc): _____

Family history of attempted/completed suicide, relation to patient and date/s: _____

Social History

Where is patient from? _____

Marital status: Married Single Widowed Divorced Separated

Describe your childhood: healthy abusive parents not together estranged foster care raised by other family members

Describe your current relationship: supportive abusive chaotic troubled satisfactory

Do you have any children: yes no Relationship is: good strained estranged

Are you satisfied with your current support system: yes no needs improvement

Level of education: Elementary Middle school High school GED Associates Bachelors Advanced degree

Job history: able to maintain work difficult to maintain work multiple jobs in last 5 years retired previous military

Occupation: _____

Alcohol use: Yes No social regular use history of DUI causes problems in relationship

Have you ever felt you needed to cut down on your drinking? Yes No
Have people annoyed you by criticizing your drinking? Yes No
Have you ever felt guilty about your drinking? Yes No
Have you ever felt you needed a drink first thing in the morning to steady your nerves or to get rid of a hangover? Yes NO

Substance use: Yes No history of use illicit use regular use prescription misuse history of treatment

Tobacco use: current use nonsmoker uses vape history of use

Past mental health treatment/counseling: none past previous IOP previous ECT

Past or pending legal issues: _____

Religious affiliation: _____

Current coping skills/stress relievers: faith exercise friends/family reading TV gardening
relaxation housework painting artwork music Other: _____