

# PSYCHOLOGICAL SERVICES OF PENDLETON, LLC

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## ADULT PATIENT HISTORY FORM

This form requests information about you that will help your provider plan your care/treatment. Please complete the form carefully and completely. The questions about your physical health or your family's health are included because some emotional/ behavioral issues are linked to physical conditions from yourself or family members. If you have any questions, please fill free to discuss them with your provider.

*If questions or statements do not apply to you please mark N/A.*

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Gender:** Male  Female  **Relationship Status:** Single  Married  Separated  Divorced  Widowed

Who referred you? \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_  
Name, Address and Telephone Number **May we contact?** Yes  No

**Emergency Contact:** \_\_\_\_\_  
Name, Telephone Number and Relationship To You

**Please list other persons living in your household, their ages, and relationship to you:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Have you ever served in the military?** Yes  No  **If yes, type of discharge:** \_\_\_\_\_

**Dates of Service:** \_\_\_\_\_ to \_\_\_\_\_ **Branch of Service:** \_\_\_\_\_

Please describe your reason for seeking treatment at this time: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Month or year in which problems or issues started: \_\_\_\_\_

What result(s) do you expect from treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PERSONAL HISTORY AND MEDICAL INFORMATION

Do you have any allergies: (ie, food, medications, hay fever)? If yes, please describe: \_\_\_\_\_

Please list any prescription medications you **currently** use. Please include name, dosage and why it was prescribed:  
If enough space is not available, you may attach list or use the back of the page.

Who prescribes these medications currently? \_\_\_\_\_  
Name and Telephone Number May we contact your prescriber? Yes  No

List any over the counter medications you **currently** use. Please include vitamins, homeopathic remedies, sleeping pills, diet pills, aspirin/ pain relievers, etc. Include name, dosage and frequency: \_\_\_\_\_

Please list previous medication prescribed for mental health symptoms and any adverse side effects you experienced:

Have you ever been hospitalized for medical/ surgical procedures? If yes, please explain: \_\_\_\_\_

When was your last physical examination? Please include date and physicians name. \_\_\_\_\_

Were there any significant findings? If yes, please explain: \_\_\_\_\_

When was your last blood test? \_\_\_\_\_ Last EKG? \_\_\_\_\_

Are you currently being treated for any medical conditions? If yes, please explain: \_\_\_\_\_

Do you have a history of blackouts, seizures or withdrawal symptoms? Yes  No  If yes, please explain: \_\_\_\_\_

Have you ever received mental health or substance abuse treatment before? Yes  No

If yes, Inpatient  Outpatient  Both  If yes, may we obtain these records? Yes  No

Are there any compulsive/ repetitive behaviors or thoughts that are of concerns to you and/or the people close to you? (i.e. fears, gambling, spending, sexual behavior, use of food, exercise, television watching, hoarding, checking, counting, washing, illness related, thoughts of harming someone or yourself, use or fear of obscene language, etc.)

Yes  No  If yes, please explain: \_\_\_\_\_  
 You may use the back of the page for lengthy answers.

**Please indicate and rate the severity (1-4) of the following issues you would like to work on in treatment:**

<b>1- NO PROBLEM</b>	<b>2- MILD PROBLEM</b>	<b>3- MODERATE PROBLEM</b>	<b>4- SEVERE PROBLEM</b>
<input type="checkbox"/> Depression	<input type="checkbox"/> Lack of friends	<input type="checkbox"/> Marriage / Relationship issues	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Loneliness	<input type="checkbox"/> Sexuality/ Sexual Issues	<input type="checkbox"/> Controlling stress	<input type="checkbox"/> Problems coping
<input type="checkbox"/> Family Conflict	<input type="checkbox"/> Loss of loved one	<input type="checkbox"/> Abused/ victimization	<input type="checkbox"/> Behavioral problems
<input type="checkbox"/> Problems at school	<input type="checkbox"/> Financial problems	<input type="checkbox"/> Eliminating a drug or alcohol habit	<input type="checkbox"/> Problems at work
<input type="checkbox"/> Legal matters	<input type="checkbox"/> Other _____		

(Please specify)

**Please indicate how the issue(s) are affecting the following areas of your life:**

	<u>No Effect</u>	<u>Little Effect</u>	<u>Some Effect</u>	<u>Much Effect</u>	<u>Significant Effect</u>
Marriage/ Relationship	1	2	3	4	5
Family	1	2	3	4	5
Job/ School Performance	1	2	3	4	5
Friendships	1	2	3	4	5
Financial Situation	1	2	3	4	5
Physical Health	1	2	3	4	5
Anxiety level/ Nerves	1	2	3	4	5
Mood	1	2	3	4	5
Eating habits	1	2	3	4	5
Sleeping habits	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to control temper	1	2	3	4	5
Spirituality	1	2	3	4	5

**Do you experience any of the following? Please mark all that apply:**

<input type="checkbox"/> Double or poor vision	<input type="checkbox"/> Unusual or excessive thirst/ dry mouth	<input type="checkbox"/> Difficulty hearing
<input type="checkbox"/> Indigestion, gas, heartburn	<input type="checkbox"/> Fainting	<input type="checkbox"/> Stomach pain
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Diarrhea or constipation	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Vomiting/ vomiting blood	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Change in appetite or eating habits	<input type="checkbox"/> Headaches
<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Coughing or wheezing	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Weakness or tiredness
<input type="checkbox"/> Palpitation or heart fluttering	<input type="checkbox"/> Swelling of hands or feet	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Problems with memory, thinking or concentration	
<input type="checkbox"/> Lumps anywhere on body – Please specify location: _____		
<input type="checkbox"/> Weight gain or loss (circle gain or loss) # lbs: _____	Time period _____	

**LIFESTYLE/ HABITS**

	(Per Day)	Hours per week spent at work/ school?
Coffee	_____	_____
Caffeinated soft drinks	_____	Specify work or school or both
Cigarettes	_____	
Alcohol	_____	
Cigars/ Pipes	_____	

	Types	Frequency
Current Exercise	_____	_____
	_____	_____
Current Hobbies	_____	_____
	_____	_____

Have you ever used drugs or alcohol? Yes  No  If yes, please list:

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>	<u>Last Date of Usage</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### FAMILY MEDICAL HISTORY AND INFORMATION

Are your parents still living? **Father** Yes  No  **Mother** Yes  No  **Parents Divorced?** Yes  No

Do you have brothers/ sisters? If yes, how many and what birth order are you? \_\_\_\_\_

Is there history of serious medical illness in your family? If yes, please explain: \_\_\_\_\_

Is there history of mental/ nervous illness in your family? If yes, please explain: \_\_\_\_\_

If yes to above, what type of treatment did they receive? \_\_\_\_\_

Does anyone in your family abuse substances and/ or alcohol? If yes, please explain: \_\_\_\_\_

Is there history of physical, emotional or sexual abuse in your family? If yes, please explain: \_\_\_\_\_

This information will help design a treatment plan geared specifically to your individual needs. Please fill free to discuss any aspect of your answers with your provider. This form is for Psychological Services of Pendleton, LLC providers only and will not be released with records or to other mental health providers.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_