PSYCHOLOGICAL SERVICES OF PENDLETON, LLC

135 SE FIRST STREET, PENDLETON, OR 97801
PHONE (541) 278-2222 FAX (541) 276-8405

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:

1- NO PROBLEM **2**- MILD PROBLEM **3**- MODERATE PROBLEM **4**- SEVERE PROBLEM

____ Depression	____ Lack of friends	____ Marriage / Relationship issues	____ Anxiety
____ Loneliness	____ Sexuality/ Sexual Issues	____ Controlling stress	____ Problems coping
____ Family Conflict	____ Loss of loved one	____ Abused/ victimization	____ Behavioral problems
____ Problems at school	____ Financial problems	____ Eliminating a drug or alcohol habit	____ Problems at work
____ Legal matters	____ Suicidal Thoughts	____ Other _____	

(Please specify)

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

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect
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:

____ Double or poor vision	____ Unusual or excessive thirst/ dry mouth	____ Difficulty hearing
____ Indigestion, gas, heartburn	____ Fainting	____ Stomach pain
____ Blackouts	____ Diarrhea or constipation	____ Convulsions
____ Vomiting/ vomiting blood	____ Paralysis	____ Blood in stool
____ Dizziness	____ Change in appetite or eating habits	____ Headaches
____ Trouble sleeping	____ Thyroid problems	____ Sexual problems
____ Coughing or wheezing	____ Chest pain	____ Weakness or tiredness
____ Palpitation or heart fluttering	____ Swelling of hands or feet	____ Joint pain
____ Shortness of breath	____ Problems with memory, thinking or concentration	

____ Lumps anywhere on body – Please specify location: _____

____ Weight gain or loss (circle gain or loss) # lbs: _____ Time period _____

LIFESTYLE/ HABITS

(Per Day)

Coffee _____

Caffeinated soft drinks _____

Cigarettes _____

Alcohol _____

Cigars/ Pipes _____

Hours per week spent at work/ school?

_____

Specify work or school or both

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

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

Substance	**Amount**	**Frequency**	**Last Date of Usage**

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**: _____