

HX-Background Information/Adult

Please Complete So That We Know You Better and Can Provide Excellent Care

Patient Name: _____ Date: _____

Patient Information

1. Age: ____ Gender: Male Female
2. Race: White African American Hispanic Asian Native American Biracial
 Other _____
3. Religion: Christian Jewish Muslim None Other _____
4. Relationship Status: Single In a Relationship Married Separated Divorced
 Widowed a. How Many Years? _____
5. Current Employment:
 - a. Unemployed Part Time Employ Full Time Employ Disabled Retired
 - b. Current Job Title: _____ Years in Position: _____
6. Children: Number: ____ If separated or divorced, who has custody of the children?
 Self Spouse/Ex-spouse Joint Custody

Current Living Situation

1. Persons Residing In the Home:

| Name: | Age | Relationship to Self | Occupation/ Grade |
|-------|-----|----------------------|-------------------|
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2. Immediate Family Members Residing Outside the Home:

| Name: | Age | Relationship to Self | Occupation/ Grade |
|-------|-----|----------------------|-------------------|
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Personal History

1. Academic History:

- a. Highest Level of Education: Some High School High School Graduate
 Associates Degree Bachelor Degree Graduate School Degree

2. Military History: No Yes; Army Navy Air Force Marine

- b. Type of Discharge: Medical Honorable Dishonorable Other

3. Medical History

- a. Past Medical Problems: Seizures Fainting Headaches Head Injury/Trauma
 Other: _____

b. Past Medical Treatment

1. Hospitalization: No Yes. If yes, number ____ Reasons: _____

2. Emergency Room Treatment: No Yes If yes, number: ____ Reason(s) _____

3. Surgeries: No Yes; If yes, number: ____ Reasons: _____

4. Current Medical Issues

- a. Allergies: None Seasonal Food, please list _____ Nuts
 Latex Pets Medication, please list _____ Other: _____

- b. Medical Problems: None Yes; _____

- c. Current Medication None Yes; Please list: _____

- d. Date of last physical exam: _____ Results: _____

1. Physician's Name/Address: _____

- e. Appetite: Good Poor, explain _____

- f. Sleep: Good Poor, explain _____

5. Mental Health History

- a. Outpatient Psychotherapy: None Yes Dates of Tx: _____

If yes, please describe _____

1. Was it helpful: No Yes

2. Why/Why Not: _____

- b. Inpatient Psychotherapy: No Yes If yes, when and where: _____

1. Problem (s): _____

- c. Mental Health Diagnoses: Unknown Yes: _____

- d. Psychotropic Medication: Current None Yes If yes, name and dosage _____

1. Past None Yes If yes, name and dosage _____

- e. Family Mental Health History: None Yes; who _____

Diagnosis _____

6. Substance Use History: Alcohol No Yes If yes, describe use: _____
- a. History of Alcohol Treatment No Yes; If yes, when _____
- b. Illegal Drug Abuse No Yes If yes, drugs used: _____
- c. History of Drug Treatment No Yes If yes, when: _____
- d. Prescription Drug Abuse No Yes If yes, drugs used: _____
- e. History of Drug Treatment: No Yes; When: _____ Where: _____
- f. Tobacco Use No Yes; Describe use _____
7. Childhood Physical/Sexual Abuse History
 None Physical Abuse Sexual Abuse; Describe: _____
8. Legal History: Arrests No Yes
- a. Charges: _____
- b. Convictions: _____
- c. Incarcerations: No Yes; Number: _____

Hobbies, Volunteer Work and Special Interests

1. Hobbies No Yes; Describe: _____
2. Volunteer Activities No Yes; Describe: _____
3. Service Organizations No Yes; Describe: _____
3. Talents and Special Skills No Yes; Describe: _____

What are Your Goals in Treatment?

1. _____
2. _____
3. _____
4. _____
5. _____

Is there Any Additional Information You Would Like to Share with Us?

 Name Date Provider