Athans and Associates, Ltd.
32 Main Street, Park Ridge, IL 60068

#5/5

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 ☐ Non-Binary
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

2. Immediate Family Members Residing Outside the Home:

Name:	Age	Relationship to Self	Occupation/ Grade

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 Condition:
   Physican:_____Address:_____ Phone:_____
   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