The Jones Center for Children's Therapy and Assessment
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ADULT (18+) PATIENT HISTORY

Name: _____ **Ethnicity:** _____ **DOB:** _____ **Age:** _____

Dear Patient,
To help establish you with our practice, please provide us with your complete medical and mental health history. Thank you and we look forward to working with you!

In your own words, please describe why you are seeking services: _____

Were you referred by an outside source, such as a medical doctor? Who? _____

Family Members/Others Residing in Your Home	**Age**	**Relationship to You**

Current Marital Status: Single Married Widowed Separated Divorced Common Law

Family of Origin

Father: _____ Age (if living/or deceased): _____
Occupation: _____ Highest Level of Education: _____
Describe your current and past father/child relationship: _____

Mother: _____ Age (if living/or deceased): _____
Occupation: _____ Highest Level of Education: _____
Describe your current and past mother/child relationship: _____

Siblings/Children/Other Important Family Members	Age	Relationship to You

With whom did you live during your childhood? _____

Where did you grow up? _____

Describe your childhood: _____

Describe your adolescence: _____

Have you experienced any significant deaths or losses? Y or N If yes, please explain: _____

Maternal Family Psychiatric History (If so, who?)
Depression/sadness_____
Suicidal ideation/attempt_____
Anxiety/excessive worry_____
Panic attacks_____
Posttraumatic Stress Disorder _____
Bipolar Disorder_____
Obsessive-compulsive tendencies_____
Schizophrenia_____
Attention problems/ADHD_____
Learning problems _____
Autism Spectrum Disorder _____
Alcohol/drug abuse_____
Problems with the law_____
Seizures_____
Other_____

Paternal Family Psychiatric History (If so, who?)
Depression/sadness_____
Suicidal ideation/attempt_____
Anxiety/excessive worry_____
Panic attacks_____
Posttraumatic Stress Disorder _____
Bipolar Disorder_____
Obsessive-compulsive tendencies_____
Schizophrenia_____
Attention problems/ADHD_____
Learning problems _____
Autism Spectrum Disorder _____
Alcohol/drug abuse_____
Problems with the law_____
Seizures_____
Other_____

Do you have a sibling(s), half-sibling(s), or child(ren) who suffers any of the aforementioned psychological issues/ disorders? Y or N If yes, who and what? _____

Medical History

Have you had any history of, difficulty with, or diagnosis of any of the following? Check the box to the right if so.

Illness	Y	Notes	Illness	Y	Notes
Allergies			Heart problem		
Arthritis			Hepatitis		
Asthma			High/low blood pressure		
Broken bone(s)			HIV+/AIDS		
Cancer			Liver problems		
Diabetes			Lung problems		
Eating disorder			Organ transplant		
Emotional problems			Osteoporosis		
Epilepsy/seizures			STD		
Fainting			Shortness of breath		
Head injury/concussion			Stroke		
Loss of consciousness			Substance/alcohol abuse		
Headaches/migraines			Tobacco use		
Hearing problems			Thyroid problems		

Have you ever had a surgery? Y or N If yes, what and why?_____

Other illnesses/medical concerns:_____

Current regularly used medications, including prescriptions, over-the-counters, herbals, and/or essential oils:

Medication	Dosage	Times/Day	For what reason

Additional prescription medications used in the past:

Medication	For what reason	Reason for discontinuation

Mental and Emotional History

Please indicate if Yes, No, or Sometimes (ST) you experience the following symptoms:

SYMPTOM	Y	N	ST	NOTES
Alcohol abuse				
Anger				
Anxiety/nervousness/worry				
Appetite fluctuations/change				
Attention problems				
Communication problems				
Conflict with child(ren)				
Depression/sadness				
Difficulty making decisions				
Divorce/separation				
Domestic violence				
Educational/school problems				
Fatigue				
Family of origin conflicts				
Feelings of inferiority/low self-esteem				
Financial problems				
Health problems				
Hyperactivity				
Illicit drug use				
Impulsivity				
Insomnia/hypersomnia				
Lack of energy				
Lack of motivation				
Learning problems				
Legal matters				
Loneliness				
Lying				
Mania				
Marital problems				
Memory problems				
Mood swings				
Nightmares				
Obsessive-compulsive tendencies				
Occupational problems				
Outbursts of rage				
Parenting problems				
Poor body image				
Poor hygiene				
Posttraumatic stress				

Prescription drug abuse				
Racing thoughts				
Religious/spiritual problems				
Self-control problems				
Self-harm (i.e., cutting)				
Sexual dysfunction				
Sexualized behavior				
Social problems				
Stealing				
Stress				
Stomach trouble				
Suicidal thoughts				
Suicide attempt				

Other Difficulties: _____

_____

Have you ever been abused? Y or N (circle one and all that may apply)
Sexually Verbally Physically Mentally Emotionally Other:_____
If Yes, who was the abuser? _____
Has you ever experienced any other traumatic event(s)? Y or N If Yes, please explain: _____

_____

Have you ever participated in therapy? Y or N Have you ever undergone psychological testing? Y or N
With whom?_____ When?_____
Was a diagnosis assigned? Y or N If yes, what? _____
Was the previous treatment beneficial? Y or N Please explain:_____

_____

_____

Have you ever been admitted for inpatient psychiatric care? Y or N If Yes, please provide details regarding admission dates, precipitating events, treatment received, perceived benefit, etc. _____

_____

_____

_____

Educational and Employment History

What is your highest level of education? _____
Are you currently attending college? Y or N If yes, what school? _____
Where did you attend high school?_____Graduation Year:_____
Did you/do you have difficulty in school? Y or N If yes, please explain: _____

_____

_____

Describe your employment history for the past five years beginning with your current position:
Employer Position Time in Job Reason for leaving

_____

_____

_____

_____

_____

_____

Have you ever served in the military service? Y or N If yes, when, where, etc.? _____

_____

Which branch? _____Rank? _____
Did you ever serve in combat? Y or N If yes, please describe your experience. _____

_____

_____

Legal History

Have you ever been arrested? Y or N If yes, please explain: _____

_____

_____

Have you ever been incarcerated? Y or N If yes, please explain: _____

_____

_____

Are problems with the law currently a concern for you? Y or N If yes, please explain: _____

_____

_____

Recreational and Leisure Activities

Do you have any hobbies? Y or N Please explain: _____

_____

_____

Do you engage in pleasurable activities with others? Y or N Please explain: _____

_____

_____

Do you attend church? Y or N Are spiritual issues important to you? Y or N Please explain: _____

_____

_____

Strengths and Weaknesses

What do you think are your biggest personal strengths?

1. _____

   _____

2. _____

   _____

3. _____

   _____

What do you think are your biggest personal weaknesses/limitations?

1. _____

   _____

2. _____

   _____

3. _____

   _____

Please provide any additional information you think we need to know.

_____

_____

_____

_____

_____

_____

Signature and Date