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ADULT PATIENT HISTORY

Name ____ **Date**_______________
Referred by ____

I. Identifying Information:

Date of birth ____ Age ______________
Home phone ____ Sex ______________
Work phone ______________________________________ Spouse's name ____________
Marital status _____________ Number of marriages _______ Present marriages (years)________
Living arrangements ____
Race/ethnic group ____

Children _____________________________________Age ________ in home Y N
_____________________________________ Age ________ in home Y N
_____________________________________ Age ________ in home Y N
_____________________________________ Age ________ in home Y N
_____________________________________ Age ________ in home Y N

Education ____
Occupation _________________________________ Number hours worked per week _____
Spouse's education ____
Spouse's occupation ___________________________ Number hours worked per week _____

Work history:

Organization ________________________ Position ________________ Years ___
Organization ________________________ Position ________________ Years ___
Organization ________________________ Position ________________ Years ___

Have you ever been on workmen's compensation or any other disability income? Y N
Are there any disability claims/applications pending now? Y N
Military History Y N

If yes, please branch ____
Highest rank ____
Type of discharge ____

Name____

II. Presenting problem or areas of needed improvement:

A. Specific problems or symptoms that prompted you to call Linda Berlin, Psy.D. & Psychological Associates?
____
____
____

B. When did you first become aware of these problems/symptoms________________
____

C. Specific stressors in your life ____
____
____

III. Symptoms checklist for the last three months:

Any change in sleeping pattern
If yes, since when ______________________________
What time do you go to sleep? _________________________
What time do you get up? _____________________________
How often do you wake up in the middle of the night? _____
What wakes you up? _______________________________________

	Yes	Sometimes	No
Difficulty getting to sleep ---	_____	_______	_____
Waking up in the middle of the night -------------------------------------	_____	_______	_____
Waking too early --	_____	_______	_____
Nightmares --	_____	_______	_____
Feeling depressed most of the day --	_____	_______	_____
Crying spells ---	_____	_______	_____
If yes, how often ____			
Feeling irritable and restless --	_____	_____	_____
Easily frustrated --	_____	_______	_____
Loss or gain of weight or appetite change --------------------------------	_____	_______	_____
Please specify ____			
Change of energy level --	_____	_______	_____
Please describe _______________________________________			
Thoughts going too fast --	_____	_______	_____
Forgetfulness --	_____	_______	_____
Dislike of one's body ---	_____	_______	_____
A lack of confidence -- -	_____	_____	_____
Moodiness --	_____	_____	_____
Loss of motivation --	_____	_______	_____
Diminished pleasure --	_____	_______	_____
Feelings of hopelessness ---	_____	_______	_____
Feelings of guilt or worthlessness ---	_____	_______	_____

Name____

Yes Sometime No

Diminished ability to think or concentrate -------------------------------- _____ ______ _____
Indecision --- _____ ______ _____
Recurrent thoughts of death or suicide ------------------------------------ _____ ______ _____
How often ____
When was the first time ____________________________________
Suicidal plans --- _____ ______ _____
Previous suicidal actions --- _____ ______ _____

Hearing voices outside your head -- _____ _____ _____
Hearing voiced inside your head --- _____ ______ _____

Feeling a need to do odd or repetitive things, such as:
Counting things for no reason --------------------------------------- _____ ______ _____
Checking locks, alarms, the stove, etc ------------------------------ _____ ______ _____
Obsessive cleanliness -- _____ ______ _____
Excessive hand washing or bathing --------------------------------- _____ ______ _____
Plucking hair --- _____ ______ _____
Making lists -- _____ ______ _____
Needing things to be perfect, symmetrical, or evenly spaced ------------- _____ _____ _____
Hearing a voice call your name or yelling at you ---------------------- _____ _____ _____
Hearing a voice telling you are bad or telling you to hurt yourself ------- _____ _____ _____
Seeing things that other people don't see, including distorted images - _____ _____ _____
Strange tastes or smells or other peculiar sensations ---------------------- _____ _____ _____
Frightening thoughts --- _____ _____ _____
Unusual beliefs --- _____ _____ _____
Ideas that seem odd or out of touch with reality ---------------------------- _____ _____ _____
Thinking the TV or radio is speaking to you -------------------------------- _____ _____ _____
Thinking that someone is out to harm you when it is not really the case - _____ _____ _____
Believing that you have special powers or that you are cursed ------------ _____ _____ _____
Sensory experiences that you cannot explain:
Visual -- _____ _____ _____
Hearing --- _____ _____ _____
Taste -- _____ _____ _____
Body sensations -- _____ _____ _____
Feeling suspicious and distrustful of others --------------------------------- _____ _____ _____
Preference of being alone and not enjoying close relationships with others _____ ____ _____
Beliefs or ideas that others find unusual or odd ------------------------------ _____ _____ _____

Have you ever felt so good or so hyper that other people thought you were not
your normal self or you were so hyper that you got into trouble? _____ _____ ______
Have you ever been so irritable that you shouted at people or started
arguments or fights? --- _____ _____ ______
Have you ever felt much more self-confident than usual? ------------ _____ _____ _____
Have you ever gotten much less sleep than usual and found you really
didn't miss it? --- ______ _____ _____
Have you ever been much more talkative or spoke much fast than usual?- ______ _____ _____

Name____

Yes   Sometime   No

Have thoughts raced through your head or you couldn't slow
or you couldn't slow your mind down?------------------------------ _____ _____ ______

Have you ever been so easily distracted by things around you that you had
trouble concentrating or staying on track? -------------------------- _____ _____ ______

Have you ever had much more energy than usual? -------------------------- _____ _____ ______

Have you ever been much more active or did many more things
than usual? --- _____ _____ ______

Have you ever been much more social or outgoing than usual?
(For example, you telephoned friends in the idle of the night) -- _____ _____ ______

Have you ever been much more interested in sex than usual? -------------- _____ _____ ______

Have you ever done things that were unusual for you or that other people
might have thought were excessive, foolish, or risky? ------------ _____ _____ ______

Has spending money ever gotten you or your family into trouble? -------- _____ _____ ______

If you check YES to ore than one of the above, have several of these ever
happened at the same time? -- _____ _____ ______

How much did these problems below the above black line cause you to be unable to work, have family, money, or legal troubles or get into arguments or fights?

(Please circle one response only)

No problem   Minor problem   Moderate problem   Serious problem

---

Yes   Sometimes   No

Have any of your blood relatives (i.e. children, siblings, parents, grand-
parents, aunts, uncles) had manic-depression illness or bipolar disorder? -- ____ _____ ____

Has a health professional ever told you that you have manic-depressive
illness or bipolar disorder? -- ____ _____ ____

Scared to death or as if you are losing your mind ---------------------------- ____ _____ ____

Shortness of breath -- ____ _____ ____

Smothering sensation --- ____ _____ ____

Accelerated heart rate --- ____ _____ ____

Trembling or shaking --- ____ _____ ____

Sweating or choking -- ____ _____ ____

Nausea or abdominal distress -- ____ _____ ____

Feeling like you or the world is not real --------------------------------------- ____ _____ ____

Numbness or tingling --- ____ _____ ____

Hot flashes or chills -- ____ _____ ____

Chest discomfort -- ____ _____ ____

Out of body experience -- ____ _____ ____

Fear of dying -- ____ _____ ____

Fear of going crazy -- ____ _____ ___

Excessive worrying -- ____ _____ ____

Dizziness --- ____ _____ ____

Fear of doing something uncontrolled --- ____ _____ ____

Name____

	Yes	Sometime	No
Fear of being in places where escape might be difficult or getting help would be difficult			
Fear of leaving home or being in your “safety zone”			
Fear of one or more situations			
Avoidance of one or more situations			
Repetitious acts or thoughts			
Strange thoughts that intrude on your mind			
Daily muscular tension			
Poor memory from early childhood			
A sense of not being yourself			
An inability to control pain			
Uncontrolled pain			
On a scale of 0-10 with 0 representing no pain and 10 representing the worst possible pain, what is your pain level most days			
Staring off into space, thinking of nothing, and losing awareness of the passage of time			
Severs and frequent headaches			
An inability to tell people how you feel and what you need			
Impulses that you cannot control			
Any worrisome eating or weight loss behavior			
Making yourself throw up			
Going without food for extended periods of time			

	Yes	Sometimes	No
Use of diet pills			
Use of laxatives			
Binge eating			
Exhaustive exercising			
Worrying about appearance that interferes with work or socializing			
Inattention			
Distractibility			
Failure to finish tasks			
Difficulties with the law			
Mood fluctuations between depression, anxiety or anger			
Self damaging acts (reckless driving, self-mutilation ,etc.)			
Tendency to be shy or nervous around others			
Inflated sense of self-importance and an intense need for admiration			
Tendency to be shy or nervous around others			
Tendency to be overly dependent on others and to need an excessive amount of reassurance form others			
Tendency to be excessively preoccupied with neatness, rules, details, etc.			
Have you ever been abused as a child or an adult?			
Sexually			
Physically			

Name____

	Yes	Sometime	No
Emotionally --	_____	_____	____
Have you experience a psychologically distressing event that is outside the range of usual human experience?-----------------	_____	_____	____

If yes, please describe:_________________________________

____

____

	Yes	Sometime	No
Do you ever re-experience the abuse or unusual experience? ------------	_____	_____	____
Have you had recurrent, intrusive recollections ? -------------------------	_____	_____	____
Have you had recurrent dreams? --	_____	_____	____
Have you acted or felt as if the event were occurring? -------------------	_____	_____	____
Have you ever seen a number of physicians for a physical problem that they have had difficulty diagnosing or treating? ------------	_____	_____	____

If yes, please describe: _________________________________

____

____

	Yes	Sometime	No
Do you have more than your share of illnesses or injuries? -------------	_____	______	____
Have you ever been physically violent? ------------------------------------	_____	______	____
Have you ever been arrested? ---	_____	______	____

If yes, please explain: _______________________________________

____

	Yes	Sometime	No
Are you presently involved in or have you ever been involved in a lawsuit?--	_____	______	___

If yes, please explain: ____

____

III: Past Mental Health History

	Yes	No
Have you ever been hospitalized for psychiatric or substance abuse problems? --	_____	_____

If so, how many times, where and at what age ___________________________

____

	Yes	No
Have you taken any medications to treat psychiatric disorders? ----------------------	_____	_____

Name medication	Prescribing Doctor	Approximate date
____________________	________________________	___________________
____________________	________________________	___________________
____________________	________________________	___________________

Have you had any counseling or psychotherapy?

Problem	Therapist	Appropriate date	Result of treatment
____________________	____________	__________________	____________________
____________________	____________	__________________	____________________
____________________	_____________	__________________	____________________

Have you ever inflicted pain or harm on yourself?

If so, when and for what purpose ____

____

____

Name____

IV: Medical History

A. Please list all current physicians, where they work, and what they are treating you for.

Current physician	Location	Medical Condition
______________________________	___________________________	______________________
______________________________	___________________________	______________________
______________________________	___________________________	______________________
______________________________	___________________________	______________________

How long has it been since your last physical examination, blood tests? ____________________

How old were you when you started menstruating (women)? ______________________________

B. Current prescription and medications and dosage, supplements, and herbal remedies

____

____

C. Prescription medications recently discontinued __________________________________

____

D. Allergies and/or drug reactions ____

____

____

E. Hospitalizations (date and reason) ____

____

____

F. Present health problems ____

____

____

G. <u>SUBSTANCE USE</u> (please check appropriate boxes)

	Yes	No	Past	Present	Frequency
Alcohol	_______	_______	_______	_______	_________
Caffeine	_______	_______	_______	_______	_________
Cigarettes	_______	_______	_______	_______	_________

Over the counter drugs (frequency and type) ____

____

____

List any other drug use in the last year (including street drugs) _____________________________

____

____

H. Developmental History

To the best of your knowledge, did any of the following prenatal, labor and delivery, or childhood problems occur during your lifetime:

	Yes	No
Illness of mother during pregnancy -------------------	____	____

Name____

	Yes	No
Medications or drugs taken by mother during pregnancy __________	_____	_____
Mother's age at birth of child was over 35 ______________________	_____	____-
Abnormal length of or difficulty with labor (longer than 8-10 hours) -	_____	_____
Forceps delivery ---	_____	_____
Caesarean section delivery ---	_____	_____
Possible anoxia in child during delivery ---	_____	_____
High fevers during childhood ---	_____	_____
Childhood convulsions ---	_____	_____
Childhood fainting spells ---	_____	_____
Childhood illnesses ---	_____	_____
Delay in learning to walk ---	_____	_____
Delay in learning to talk --	_____	_____
Delay in toilet training --	_____	_____
School difficulties in learning --	_____	_____
Behavior problems in school or at home ---------------------------------------	_____	_____
Repeated grades --	_____	_____
Special education --	_____	_____

I. General Health

	Yes	**No**
Any significant injuries ---	_____	_____
Head injuries --	_____	_____
Visual problems --	_____	_____
Hearing problems --	_____	_____
Blackouts --	_____	_____
Memory problems ---	_____	_____
Onset of memory problems____________________________	_____	_____
Language disturbances --	_____	_____
Disturbance in coordination or gait ---	_____	_____
Episodes of uncontrolled behavior in the absence of provocation -------	_____	_____
High blood pressure --	_____	_____
Heart disease ---	_____	_____
Lung disease --	_____	_____
Asthma or allergies ---	_____	_____
Cancer ---	_____	_____
Blood sugars too high or too low ---	_____	_____
Glaucoma ---	_____	_____
Seizures ---	_____	_____
Kidney disease ---	_____	_____
Liver disease --	_____	_____
Thyroid disease --	_____	_____
Male/Female problems --	_____	_____

V. **Family History**

A. Mother's name ____ Age ____

Father's name ____ Age ____

List of siblings in order, oldest to youngest, with their ages

Name____

____
____
____

B. Please list any significant medical illnesses among blood relatives and who had what illness __
____
____

C. Is there any history of psychological problems in your family of origin? (anxiety, depression, mood swings, erratic behavior, schizophrenia, ADHD, etc) _____Yes _____ No

If yes, please list their name and relation to you along with their problem_________________
____
____

Has anyone in your family of origin received mental health treatment or hospitalization for emotional problems? _____ Yes _____ No

If yes, please list their name and relation to you along with their problem_________________
____
____

D. Is there any history of alcohol or substance abuse in your family or origin (parents or siblings)? _____ Yes _____ No

If yes, please list their name and relation to you ____________________________________
____
____

Has anyone in your family of origin received treatment for alcohol or substance abuse? _____ Yes _____ No

If yes, please list their name and relation to you ____________________________________
____
____

E. If you have grandchildren, how many do you have? __________________________________

How often do you see them? ____

VI. Marital and Relationship History

Spouse/Partner's Age: ____________ Spouse/Partner's occupation: ___________________________

Spouse/Partner's personality (In your own words):____
____

Check areas where problems exist:

Children _____ Finances _____ Religious differences _____ In-laws _____ Communication _______

Arguments _____ Friends _____ Substance Abuse _____ Physical abuse _____ Sex _____ Work ____

Verbal abuse _____ Affairs _____ Recreation/leisure _____ Emotional abuse _____ Other: _________
____

How do you get along with your in-laws? (including brothers and sisters-in-law):
____

____

Give details of any previous marriages or long-term relationships:
____

____

Please list family members who you believe are supportive of you or who you can trust to help you when you are in a crisis: ____

____

Please list friends or social groups who you believe would be supportive of you or who you can trust To help you when in a crisis ____

____

Thank you for your time and patience in completing this questionnaire. Please present this history form to the receptionist for the clinician to review prior to your appointment.

All the answers and information contained in this history form are accurate to my knowledge. Any question or request for information left blank was done intentionally. I may not know the answer or I wish not to reveal this information at this time.

Signature_______________________________________ **Date**____________________