FAMILY HEALTH CARE
ADULT INITIAL HISTORY FORM
(AGES 18 +)

We believe that behavioral and emotional health is important to a person's overall health. That's why we have a Behavioral Health Team at our clinic. To help us best assess this critically important part of your health, please fill out the attached 4 forms. The information you provide will help your counselor better understand how to help you move forward.

- **The Adult Initial History Form** - 2 pages: This form asks about your main problems and symptoms. It gives us an overall view of your Behavioral Health history. It also includes what's called an "impairment rating scale." This scale tells us how much you think your problems are affecting your life at home or at work.

- **The PHQ-9 - Patient Health Questionnaire** - 1 page: This form asks questions about your recent feelings and behaviors. Your answers help us check for signs and symptoms of depression.

- **The MDQ – Mood Disorder Questionnaire** - 1 page: This form helps us check for signs and symptoms of a possible mood problem called bi-polar disorder.

- **The GAD - 7 Anxiety Scale** - 1 page: This form helps us check for problems related to stress/anxiety in your life.

Please complete these forms as completely and accurately as you can. Your counselor will ask for them and go over them with you during your first appointment. We find them very helpful in understanding your situation more quickly so we can better know how to start helping things improve.

If you have any questions or concerns, please call us at the clinic you are visiting:

- Cadillac (231)-775-6521
- Baldwin (231) 231-745-4624
- Grant (231) 834-0444
- White Cloud (231)-689-5943

Thank you,

The Behavioral Health Team

FHC Behavioral Health Services
Adult Initial History (page 1 of 2)

Today's Date: _____ **Patient's Name:** _____ **Date of Birth:** _____

1. What are the main problems or concerns you are dealing with?

Physical: 1. _____ 2. _____ 3. _____
Emotional: 1. _____ 2. _____ 3. _____

2. Have you been treated for mental health disorders in the past? ☐ **Yes** ☐ **No** **If Yes**, how many episodes? _____

What treatments were tried? ☐ meds ☐ therapy ☐ hospitalization ☐ other :_____
Was treatment successful? Explain: _____

3. Have you experienced any of the following conditions in the past 6 months?

Yes	No		Yes	No		Yes	No	
☐	☐	Chest pain	☐	☐	Shortness of breath	☐	☐	Tension headache
☐	☐	Fatigue	☐	☐	Back pain	☐	☐	Migraine headache
☐	☐	Dizziness	☐	☐	Stomach ache	☐	☐	Irritable bowel syndrome

Have you been diagnosed with a chronic medical condition? ☐asthma ☐diabetes ☐other:_____
Are you experiencing any physical pain? ☐Yes ☐No
If yes, how bad is your pain? ☐not present ☐a little bad ☐pretty bad ☐very bad ☐couldn't be worse

4. Sleep assessment

Do you have problems sleeping? ☐ Yes ☐ No If **Yes**, answer the following:
How long have you had sleep problems? _____
On average, how many nights per week do you have sleep problems? _____
On average, how many hours do you sleep when you're having problems? _____
Which of the following best characterizes your sleep problem?

- ☐ I have trouble falling asleep. I usually fall asleep at: ____ pm/am
- ☐ I frequently wake up during the night.
- ☐ I wake up early and can't fall back to sleep.
- ☐ I sleep all the time and want to take naps.

How bad would you say your sleep problem is? ☐ not present ☐ a little bad ☐ pretty bad ☐ very bad ☐ couldn't be worse

5. Medications

Are you taking—or have you taken—any medications **for emotional problems** (such as depression or anxiety)? ☐Yes ☐N0
If **Yes**, please complete the information below for each medication. If you need more space, use the back of this page.

Name of medication	Dose	When Started?	Still Taking?	How well did it work?	What side effects?

6. Eating/Weight/Body

- ☐ **Yes** ☐ **No** Do you eat fruits and vegetables every day?
- ☐ **Yes** ☐ **No** Do you drink milk and/or eat milk products every day?
- ☐ **Yes** ☐ **No** Do you do things to lose weight (skip meals, take pills, starve yourself, vomit, etc)
- ☐ **Yes** ☐ **No** Do you work, play, or exercise enough to make you sweat or breathe hard at least 3 times a week?

7. Family history:

Who did you live with growing up? (Check all that apply)

☐ Mother	☐ Stepmother	☐ Brother(s)
☐ Father	☐ Stepfather	☐ Sister(s)
☐ Guardian	☐ Other adult relative	☐ Other/(explain)_____

What was your childhood family experience like? (Check all that apply)

☐ outstanding home environment ☐ normal home environment ☐ uninvolved home environment ☐ chaotic home
☐ love and respect by mother ☐ love and respect by father ☐ love and respect by siblings
☐ witnessed physical/verbal/sexual abuse toward others ☐ experienced physical/verbal/sexual abuse from other

☐ **Yes** ☐ **No** Do you have any biological relatives who have behavioral, emotional, or psychiatric problems?
If Yes, Who? ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Grand Mother ☐ Grand Father ☐ Aunts ☐ Uncles
If Yes, What Problems? ☐ depression ☐ anxiety ☐ bipolar disorder ☐ drug or alcohol abuse ☐ suicide,
☐other:_____

8. History of abuse and traumatic events: Do you have a history of any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Drug or alcohol abuse	☐	☐	Emotional abuse	☐	☐	Traumatic events
☐	☐	Physical abuse	☐	☐	Sexual abuse			
☐	☐	Are any of the above occurring now, or still affecting you?						

If **Yes,** have you sought help from a professional? If so, who? _____

9. Current Family

During the past year, have there been any changes in your family such as: (Check all that apply)

☐ Marriage ☐ Loss of job ☐ Births ☐ Other changes_____
☐ Separation ☐ Moved to a new neighborhood ☐ Serious Illness/Injury _____
☐ Divorce ☐ A new school ☐ Deaths _____

Yes ☐ **No** Are you currently in a relationship/married?
Yes ☐ **No** Are you getting along with your partner/spouse?
How many children do you have? _____
Yes ☐ **No** Do any of your children present specific problems?
Yes ☐ **No** Do you know at least one person who you can talk to about problems?
Yes ☐ **No** Do you think that your family or friends usually listen to you and take your feelings seriously?
Yes ☐ **No** Are you worried about problems at home or in your family?

10. Substance use and other habits in the past year

☐ **Yes** ☐ **No** Do you use alcohol?
If yes, about how often? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Seldom ☐ Never
☐ **Yes** ☐ **No** Have you felt the need to cut down on your drinking or use of other drugs?
☐ **Yes** ☐ **No** Have people annoyed you by criticizing your drinking or use of other drugs?
☐ **Yes** ☐ **No** Have you felt guilty about your drinking or use of other drugs?
☐ **Yes** ☐ **No** Have you felt you needed a drink or other drug in the morning to get going, steady your nerves, or get rid of a hangover?
How many days in the past month have you had more than five drinks on a single occasion? _____
☐ **Yes** ☐ **No** Do you smoke? If so, about how many cigarettes per day? _____
☐ **Yes** ☐ **No** If you DO smoke, do you think that it is a problem in your life?

11. Employment/Financial

☐ **Yes** ☐ **No** Are you currently employed? If Yes, What do you do?_____
☐ **Yes** ☐ **No** Does your present work satisfy you?
☐ **Yes** ☐ **No** What kind of jobs have you held in the past?_____
☐ **Yes** ☐ **No** Do you have any special vocational training or skills? If Yes, What are they?_____
☐ **Yes** ☐ **No** Have you ever been fired from your employer?
☐ **Yes** ☐ **No** Do you have any work-related problems or difficulties in school?
☐ **Yes** ☐ **No** Does your current monthly income meet your basic living expenses?
☐ **Yes** ☐ **No** Do you have large indebtedness or outstanding bills?
☐ **Yes** ☐ **No** Do you have relationship conflicts over money?
☐ **Yes** ☐ **No** Have you ever served in the Military?

12. Legal/Violence/Safety

☐ **Yes** ☐ **No** Is there a gun, rifle, or other firearm where you live?
☐ **Yes** ☐ **No** Have you ever carried a gun, knife, club, or other weapon to protect yourself?
☐ **Yes** ☐ **No** Have you ever been in a physical fight where you or someone else got hurt?
☐ **Yes** ☐ **No** Have you ever been in trouble with the police, arrested or spent time in jail?
☐ **Yes** ☐ **No** Have you ever been on probation or parole?
☐ **Yes** ☐ **No** Have you ever seen a violent act take place at home, school, or in your neighborhood?
☐ **Yes** ☐ **No** Are you worried about violence or your safety?

13. Cultural/ Leisure/Spiritual

What is your race/ethnicity? _____
☐ **Yes** ☐ **No** Do you currently practice the values and beliefs of your culture or ethnicity?
☐ **Yes** ☐ **No** Are you currently engaged in community or recreational activities or hobbies? Please list: _____
☐ **Yes** ☐ **No** Have you done something fun during the past two weeks? If Yes, What did you do?_____
☐ **Yes** ☐ **No** What is your religion and/or spirituality?_____
☐ **Yes** ☐ **No** Are you currently participating in spiritual activities? _____