Family Health Care

Patient Name: _____ Patient DOB: _____ Today's Date: _____

ADULT INITIAL HISTORY

Today's Date: _____ __ Patient Name: _____ Patient DOB: _____

Emergency Contact Name and Phone: _____

Is it okay to contact this person in case of an emergency? ☐ Yes ☐ No Initials: _____

E-Mail Address: _____

***In order to participate in Telehealth virtual visits, we must be able to send you a log-in link to your e-mail address. By listing your e-mail above, you are giving us consent to contact you regarding appointments via e-mail. ***

Completing this form is an important part of the assessment process. Please complete this form in its entirety. If you have questions or concerns, you will have the opportunity to discuss them with your therapist.

PRESENTING PROBLEM

1. Have you ever seen a Mental Health Therapist before? ☐ Yes ☐ No

   If so, name of therapist: _____

2. Please describe what brings you in today: _____

2. How long have you been experiencing this issue? ☐ 0-6 Months ☐ 6-12 Months ☐ 1-5 Years ☐ 5+ Years

3. On a scale of 1 to 10, please rate the intensity of this issue (1 being mild, 10 being severe): _____

4. How does your mental health interfere with your daily function? _____

_____

5. What are you hoping to gain from therapy? _____

_____

6. Place a check mark next to any symptom(s) you are currently experiencing, or have experienced in the past 30 days.

☐ Sadness	☐ Hopeless/Helpless	☐ Sleep Too Much	☐ Fatigue/No Energy
☐ Poor Memory	☐ No Motivation	☐ Lack of Interest	☐ Suicidal Thoughts
☐ Guilt	☐ Fear	☐ Feeling Worthless	☐ No Appetite
☐ Prefer Being Alone	☐ Irritable/Angry	☐ Can't Sleep	☐ Too Much Energy
☐ Not Tired	☐ Talking Fast	☐ Implusive	☐ Trouble Concentrating
☐ Restless	☐ Suspicious	☐ Hearing Voices	☐ Hallucinations
☐ Nervousness	☐ Panic Attacks/Anxiety	☐ Avoidance	☐ Can't be in large crowds

7. Do you ever think about dying? ☐ Yes ☐ No
8. Are you a trauma survivor? ☐ Yes ☐ No

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TOBACCO

1. Have you ever used any forms of tobacco, including vaping? (cigarettes, snuff, etc) ☐ Yes ☐ No

IF NO, SKIP TO NEXT SECTION

2. What form(s) of tobacco have you used in the past/are currently using? _____
3. How many times daily, on average, do you use tobacco (1-99 times)? _____
4. Have you ever been involved in a program to help you quit using tobacco in the past 30 days? ☐ Yes ☐ No

If so, which group did you participate in? _____

SUBSTANCE USE/ADDICTION (CURRENTLY)

1. Would you or someone you know say you are having a problem with alcohol? ☐ Yes ☐ No
2. Would you or someone you know say you are having a problem with Marijuana? ☐ Yes ☐ No
3. Would you or someone you know say you are having a problem with other addictive behaviors? (i.e. caffeine, gambling, pornography, or shopping?) ☐ Yes ☐ No
4. Do you have a family history of addiction of any form? ☐ Yes ☐ No

If yes, please describe: _____

PERSONAL, FAMILY, AND RELATIONSHIPS

1. Has there been any significant person or family member that has left your life in the past 90 days? ☐ Yes ☐ No
2. How are the relationships in your family/support system?

☐ Good ☐ Fair ☐ Poor ☐ Close ☐ Stressful ☐ Distant

3. Are there any current issues with your family/support system?

☐ Conflict ☐ Abuse ☐ Stress ☐ Loss ☐ Other

4. What is your marital status?

☐ Single ☐ Married ☐ Life Partner ☐ Separated ☐ Divorced ☐ Widowed

5. Have you ever had problems with your significant other? ☐ Yes ☐ No

If yes, please explain: _____

6. Do you have problems with friendships? ☐ Yes ☐ No
7. Do you get along easily with others? (neighbors, coworkers, etc) ☐ Yes ☐ No
8. What are some of your hobbies? _____

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EDUCATION

1. What is the highest level of education you have completed? _____

2. Would you describe your school experience as positive or negative? ☐ Positive ☐ Negative

3. Are you currently attending school or vocational training? ☐ Yes ☐ No

LEGAL

1. Have you ever been arrested? *If no, skip to next section* ☐ Yes ☐ No

   If yes, what were you arrested for? _____

2. Have you ever been convicted of a crime? ☐ Yes ☐ No

   If yes, how long were incarcerated for? _____

3. Are you currently on probation or parole? ☐ Yes ☐ No

WORK

1. Current Employment Status:

☐ Employed FT ☐ Employed PT ☐ Unemployed ☐ Disabled ☐ Retired

2. What is your work history like?

☐ Good ☐ Poor ☐ Sporadic ☐ Never Employed

3. Have you ever served in the military? ☐ Yes ☐ No If yes, branch/rank: _____

MEDICAL

1. Are you currently pregnant? ☐ Yes ☐ No If yes, what is your due date? _____
2. Are you at risk for HIV/AIDS/STD's (unsafe sex, using needles, etc)? ☐ Yes ☐ No
3. Has your physical health kept you from participating in activities? ☐ Yes ☐ No

Current Primary Care Physician: _____ Phone Number: _____

Current Medical Issues: _____

_____

Current Medications: _____

_____

Is there anything that you would like me to know about you? _____

_____

_____