Northwest Behavioral Health Services

Adult History Form

Please complete as much of this from as you can and bring with you to your first session. This information will help your counselor understand you better.

Patient Name: _____ **Date of Birth:** _____
Name of person completing form (if different from the patient): _____
Relationship to Patient: _____

Emergency Contact: _____ **Phone Number:** _____
Relationship to Patient: _____

Do you have a guardian or payee? ☐ Yes ☐ No
Name: _____
Relationship: _____ Phone Number:_____

Please check the items that best describes you:

☐ Single ☐ Married ☐ Remarried ☐ Partner or significant other
☐ Separated ☐ Divorced ☐ Widowed ☐ Other_____

Please describe your living situation. Check all that apply:

☐ With spouse ☐ With partner or significant other ☐ With children
☐ With parents ☐ Alone ☐ With Roommate ☐ Other_____

Please tell us if you are working. Check all that apply: ☐ Employeed ☐ Unemployeed
☐ Retired ☐ Disabled ☐ Full-time parent ☐ Volunteer ☐ Other_____

If you are working outside the home (in a paying job or as a volunteer), describe the job and how long you have held it:_____

Ethnicity, culture and religion

Please share any ethic, cultural or religious concerns that may be helpful to your therapist:

_____

Is English your preferred language? ☐ Yes ☐ No If no, list language:_____

Would you like an interpreter or other support involved in your therapy?_____

Mental Health and Chemical History

Please check any of the items that apply to you now or in the past 3 months:

○ Depression ○ Crying spells ○ Hopelessness ○ Relationship Break-up ○ Loneliness ○ Emptiness ○ Loss of Appetite ○ Trouble sleeping ○ Nightmares ○ Thoughts of harming yourself ○ Spending money ○ Gambling ○ Feeling nervous or anxious ○ Panic attacks ○ Can't concentrate ○ Confusion ○ Thoughts of harming others ○ Suicide attempts or injuries ○ Hearing voices	○ Seeing things others don't ○ Unusual thoughts ○ More alcohol than usual ○ More drugs than usual ○ Blackouts or memory loss ○ Withdrawal from Substances ○ Mood swings ○ Racing thoughts ○ Fear of dying ○ Job stress ○ Less activity than normal ○ Not seeing friends (isolating self) ○ Worrying ○ Fear of loss ○ Loss of control of alcohol or drug use ○ Overeating Bingeing	○ Purging ○ Yelling or breaking things ○ Hitting people ○ Endangering yourself ○ Endangering others ○ Feeling controlled ○ Feeling talked about ○ Feeling guilty or ashamed ○ Paranoia ○ Grief ○ Sexual problems ○ Problems with school or job ○ Feeling intimidated ○ Violence or fear in the home ○ _____

Please explain the items that you checked:_____
_____

Are you current problems affecting your daily life, if so please explain?_____
_____
_____

Present Concerns

Describe the problem or event that brought you here today? _____
_____
_____

What would you like for your counselor /provider/staff to do for you? _____
_____
What has led you to seek help at this time? _____
_____
Have you already tried to resolve these concerns? If so, what did you do and how did it work?_____
_____
Who do you go to for support (family, friends, faith or spirituality, support or self-help groups)?_____
_____

What strengths or resources do you have that will help you succeed in counseling? (Examples: commitment, strong family support, intelligence, good social support, church, friends, etc.)

_____

_____

What might prevent your success in counseling? (Examples include: few friends, financial stress, lack of social support, lack of family support, etc?) _____

_____

What are some of your hobbies or interest? _____

_____

Military Service

Have you been or are you currently in the military? ☐ Yes ☐ No Branch_____

Date of discharge_____ Type of Discharge_____ Rank _____

Were you in combat? ☐ Yes ☐ No

Personal History

Tell us about your childhood:

Where did you grow up?_____

Were your parents always marred, or was there a divorce? _____

If they divorced, how old were you at the time? _____

How many siblings do you have? _____ What is your birth order? _____

How would you describe your childhood? _____

Tell us about your current family. Please list the members of your family and household below.

Name	Age	Relationship	Living in same house? (Circle)
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

How would you describe relationships in your current family?_____

_____

Tell us about other marriages or committed relationships you have had.

Length of: _____

Do you have children from other relationships? ☐ Yes ☐ No

If yes, give names and ages (unless already named above):_____

_____

Legal Status

Have you ever been involved with the legal system (child custody, order of protection, DWI, etc.)?

☐ Yes or ☐ No If yes, please describe: _____

_____

Education

Please list the highest grade you have completed and any certificates or licenses you hold in a specialty:

_____

Do you have learning problems in any of these areas? ☐Speech ☐ Hearing ☐Reading

☐Writing ☐ Concentration ☐Attention ☐Other_____ ☐None

If you have problem areas or a preferred way to learn, please describe:

_____

Mental Health and Chemical dependency in your family or origin

Please list any relatives (blood relatives) who have had mental health issues.

Depression:_____

Bipolar/manic depression:_____

Anxiety (panic attacks, obsessive-compulsive disorder, phobias): _____

_____

Schizophrenia: _____ Suicide: _____

Eating Disorder: _____ Attention deficit disorder: _____

Drug or alcohol abuse or dependency: _____

Your mental health and chemical dependency history

Yes	No	Type of Treatment	When	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/Support Groups			

Please check any of the following that apply:
In the past year, I have:

- ☐ thought I should cut down on my drinking
- ☐ had people comment about my drinking
- ☐ felt bad or guilty about my drinking
- ☐ thought I should cut down on my drug use
- ☐ had people comment about my drug use
- ☐ felt bad or guilty about my drug use
- ☐ used drugs or alcohol as an eye-opener first thing in the morning to steady my nerves, to get rid of a hangover or to get my day started.
- ☐ considered talking to someone about my drug or alcohol use.

Substance Use History

Substance Type	Current Use (last 6 months)				Past Use				When did
	Y	N	Frequency	Amount	Y	N	Frequency	Amount	You Start?
Tobacco									
Caffeine									
Alcohol									
Marijuana									
Cocaine/crack									
Ecstasy									
Heroin									
Inhalants									
Methamphetamines (Meth)									
Pain Killers									
PCP/LSD									
Steroids									
Tranquilizers									

List any problems you have had because of the drinking or drug use (with friends, the law, your money, your job, sex, school, family): _____

_____

Trauma and abuse history

Describe any major losses you have had (such as death, disability, divorce, relationship changes)

_____

_____

_____

Please check if you child has experienced any of the following types of trauma or loss:

- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Domestic Violence
- ☐ Discrimination
- ☐ Witnessing abuse of another
- ☐ Violence in the home
- ☐ Crime victim
- ☐ Parent illness
- ☐ Placed a child for adoption
- ☐ Feeling of Intimidation
- ☐ Financial problems
- ☐ Homelessness
- ☐ Loss of a loved one
- ☐ _____

Safety Concerns

Have you ever **thought about** hurting or killing yourself, or had a desire to do so? ☐ Yes ☐ No

If yes, do you have a suicide plan? ☐ Yes ☐ No

If so, please explain:_____

_____

Have you ever tried to hurt or kill yourself? ☐ Yes ☐ No

If yes, list the date and method: _____

_____

Have you ever harmed property or people, or thought about causing harm? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you have access to firearms? ☐ Yes ☐ No

Medical Status

Do you have a psychiatrist? ☐ Yes ☐ No Name of psychiatrist_____

Phone (____)_____ Fax (____)_____

Do you have a primary care clinic or doctor?

Name of clinic or doctor_____

Phone (____)_____ Fax (____) _____

Have you had a physical exam to check for your symptoms? Yes ☐ No ☐

Date of your last physical exam_____

Have you ever had any major medical problems? ☐ Yes ☐ No If yes, please explain: _____

_____

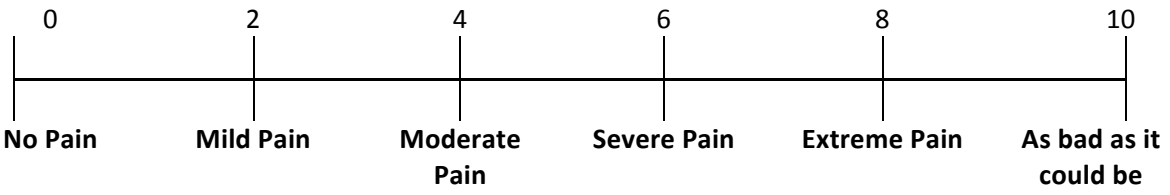
_____

Do you currently have any physical pain? ☐ Yes ☐ No If yes, please explain: _____

_____

_____

Is your pain constant or chronic (recurring or ongoing)? ☐ Yes ☐ No



Are you concerned about your weight or eating habits? ☐ Yes ☐ No

Are other people concerned? ☐ Yes ☐ No

If yes, have you spoken to your doctor about the concerns? ☐ Yes ☐ No

If yes to either question, please explain:_____

_____

Please list all current medications:

Medication	Doctor	How often are you taking?	Dosage/MG

If you need more space, please attach another sheet of paper or write on the back.

Do you have any allergies? ☐ Yes ☐ No
Have you ever had a bad reaction to medication? ☐ Yes ☐ No
If yes to either question, please describe:_____
_____

Patient Signature:_____ Date:_____

*Reviewed by: Therapist/Provider Signature*_____ *Credentials*_____ *Date*_____