

CENTER FOR PSYCHOLOGY AND COUNSELING
118 E. Sunbridge Dr.
Fayetteville, AR 72703
479-444-1400

PATIENT HISTORY – ADULT FORM

This form is for the PATIENT'S childhood history. All questions are about **you**, not about your children.
Please complete this form to the best of your ability.

Patient's Name: _____ Birth Date: _____ Age: _____ Sex: _____

Who referred you to this clinic? _____

FAMILY INFORMATION:

Parent's name: _____ Birth Date: _____
Occupation: _____ Employer: _____
Highest School Grade Completed: _____ Other training: _____
Religion: _____

Parent's Name: _____ Birth Date: _____
Occupation: _____ Employer: _____
Highest School Grade Completed: _____ Other training: _____
Religion: _____

Marital Status of parents: _____ Marriage Date: _____
Date divorced, if applicable: _____ Death of parent, if applicable: _____

Who do you live with: Alone / Spouse/Partner / Roommates
Other: _____

How long have you lived at the current address? _____

Where else have you lived during your life? _____

List all persons living in the home:

NAME	AGE	RELATIONSHIP TO PATIENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRESENTING CONCERNS:

What do you think is your main problem?

What do you believe caused your problem?

What have you been told by doctors, teachers and / or others about your problem?

Do you have concerns about other family members? Y / N (if yes, please explain)

What do you expect or hope to have happen as a result of an evaluation?

PATIENT'S BIRTH HISTORY:

Was the pregnancy planned? Y / N

Medical Care began in the ___ month of pregnancy

___ Routine ___ Sporadic

Birth was: Vaginal / Caesarean / Breech / Twins or more

Birth weight: _____

Were there any complications? Y / N (if yes, please explain)

CHILDHOOD GROWTH AND DEVELOPMENT:

Did you have any developmental delays in the following areas (Please circle all that apply):

Motor Skills / Language and Hearing / Feeding Problems / Social Skills (if yes, please explain)

How many **hours of sleep** do you get per night? _____

MEDICAL HISTORY:

Please list the names and addresses of other professionals who have worked with you and your family.

Physician _____
 Psychologist/Counselor _____
 Other (please specify) _____

Please list any medications and dosages that you are **currently** taking:

Please also list any medications you have taken in the **past** and have discontinued:

Do you have any allergies to medications? Y / N (if yes, list below)

Have you ever been hospitalized? Y / N (if yes, explain below)

Have you ever had a serious illness or accident? Y / N (if yes, explain below)

Do you have a history for any of the following:

- Headaches Head Trauma/Concussions Seizures
- Heart Disease Glaucoma Liver Disease
- Hallucinations

If yes, please describe, indicating age and complications:

SCHOOL HISTORY:

Please complete the following about yourself, beginning with the first you can remember and ending with current placement. (If need more room, use other side of this page)

School	City/State	Grade or class placement	Dates of Attendance
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY:

Please note below if any of your relatives have had any of the following conditions. (For example: brother, parent, grandparent, aunt, cousin)

	Relationship to patient
Over active/Attention problems	_____
School Difficulties	_____
Speech Problems	_____
Emotional Problems	_____
Mental Illness (If yes, please explain below)	_____

What stressors have impacted your family recently? (i.e., deaths, marital conflicts, financial worries, etc.)

BEHAVIOR:

If you answer **yes** to any of the following, please explain below the question.

How many weekends out of 4 do you “drink more than you should”?

Do you ever use any illegal drugs or substances Y / N

Are you having any legal issues? Y / N

Are you having any problems with your behavior? Y / N

Please use this space for any other information you feel will be helpful to us in your evaluation.