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Adult History Form

Please print and accurately complete every blank on this form.

Patient Name: _____ Date of Birth ___ /___/____
Appointment Date _____
Why are you coming to see Dr. Cantwell today and how do you hope he can help you?

_____
_____
_____
_____
_____
_____
_____
_____***Additional Blank Sheet of Paper – CIRCLE ARROW***→

Medication Allergies: _____ →
Current Psychiatric Medications: Name/Dose/Directions/Benefit/Side Effects:

_____
_____
_____
_____
_____
_____
_____→

Current Other Medications: Name/Dose/Directions/Condition Treated:

_____
_____
_____
_____
_____
_____
_____→

Current Counselor: Name _____ Phone Number_____
Appointment Frequency _____ How long seen? _____
Primary Care Provider: Name _____Phone Number_____
Other Medical Providers Name/Number: _____

_____
_____
_____
_____→

COMPLETE & SIGN A SEPARATE RELEASE OF INFORMATION/MEDICAL RECORD REQUEST FOR ALL

PSYCHIATRIC HISTORY:
Previous psychiatrist name(s), when & how long seen? _____
_____→
Past counselor name(s), when & how long seen? _____
_____→
Prior Psychiatric Hospitalizations or Substance Rehabilitation: Yes ____ No _____
Where, when & how long? _____
_____
_____→
Suicide Attempts: Yes _____ No _____How many times? _____ When was the first? _____
When was last? _____ How did you attempt? _____
Other Self Harm: Yes _____ No _____How many times? _____ When was the first? _____
When was last? _____ How did you harm yourself? _____
Psychiatric Diagnoses: _____
_____→
Abuse History: Physical ___ Sexual ___Emotional ___ (Describe When, What & By Whom)
_____
_____→

SUBSTANCE USE HISTORY:
Tobacco: Yes ____ No ____, How much/how often? _____
Caffeine: Yes ____ No ____ How many per day? _____ What is your cut off time? _____
Alcohol: Yes _____ No ____ How much/how often? _____
Drugs, including but not limited to marijuana, cocaine, crack, ecstasy, LSD, mushrooms, meth/amphetamines, opiates, benzodiazepines, inhalants, etc.):
List any recreational drugs you've taken, how often you take them, and when was last time?
_____
_____
_____
_____
_____→

Past Psychiatric Medications: Name/Maximum Dose/Benefits/Side Effects/How Long Taken
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____→

MEDICAL & SURGICAL HISTORY: List ALL Medical Problems & Surgeries in Your Lifetime

_____
_____
_____
_____
_____
_____
_____→

PSYCHOSOCIAL HISTORY: Marital Status (Circle) Single, Married, Divorced, Widowed
If married, how long? _____. If divorced or widowed, how long ago, and after how many years of marriage? _____
If previously married, how many times & how long was each marriage? _____
_____
CHILDREN: How many girls/boys & ages? _____
_____
EDUCATION: How far did you go in school? _____
What is your highest degree? _____
EMPLOYMENT: What type of work do you do? _____
How long in current position? _____
Arrests/legal problems (Detail): _____
Military Service (Describe): _____ Type of Discharge: _____
Spouse Name/Age/Employment: _____
SIBLINGS: How many sisters/brothers & their ages? _____
_____
PARENTS: (Age & Circle **L**iving or **D**eceased): Mother _____ L D Father _____ L D
Married Yes ____ No ____ How long? _____
If divorced, how old were you when they divorced? _____

BIOLOGICAL FAMILY HEALTH HISTORY: (Depression, Anxiety, Bipolar, Schizophrenia, Substances, Dementia, ADHD, Learning Disabilities, Thyroid Disorders, Neurologic Disorders, etc.)

_____
_____
_____
_____
_____
_____→

PSYCHIATRIC REVIEW OF SYSTEMS:
Sleep: How long does it <u>usually</u> take to fall asleep? _____
Number of awakenings/night & time to fall back to sleep? _____
Average total hours sleep: Workdays _____ Off Work _____
Describe your appetite _____
Binging/Purging (Describe/Frequency) _____
Weight gain +/loss – (lbs.) _____ in _____ time
Describe your energy _____

CHECK ALL SYMPTOMS THAT APPLY TO YOU IN THE PAST SEVERAL WEEKS TO MONTHS:

Depression: Sad ___, Hopeless ___, Helpless ___, Worthless ___, Guilt ___, Crying ___, Indecisive __
Irritability ___, Social Isolation ___, Loss of Motivation ___, Loss of memory/concentration ___,
Loss of interest/pleasure ___, Decreased sex drive ___, Pessimism ___, Wishing You were Dead ___,
Thoughts of Killing Yourself ___, Thoughts of Hurting Yourself ___, What specifically have you thought about doing to kill or hurt yourself? _____
_____
When is the *last time* and *how* did you try to hurt or kill yourself? _____
_____
Who did you tell and *what medical treatment* did you seek for it? _____
_____
Do you regret failing and why? _____
_____
Thoughts of harming others _____, Describe thoughts of harming others _____
_____.
Mania: Elevated or Euphoric Mood ___, Rage ___, Excessive/Fast Talking ___, Racing Thoughts ___,
Increased Energy ___, Increased Activity ___, Impulsivity ___, Grandiose Thinking ___,
Increased Sex Drive ___, Spending Sprees ___, Risk Taking ___, Recklessness ___, Invincible ___,
Anxiety: Nervous ___, Excessive Worry ___, Ruminating ___, Muscle tension ___, Avoidant ___,
Overwhelmed ___, Panic ___, Feeling of Doom/Terror ___, Tremor ___, Shortness of Breath ___,
Chest Discomfort ___, Heart Pounding ___, Numbness/Tingling ___, Nervous stomach ___,
Obsessing about weight gain ___, Nightmares ___, Intrusive Thoughts ___, Increased Startle ___,
Flashbacks of Traumatic Events ___, Germ Phobia ___, Excessive Hand Washing ___,
Excessive Orderliness ___, Excessive Cleaning ___, Perfectionistic ___, Compulsive Behaviors/Rituals (Describe)_____
Fears of: Leaving Home ___, Being Alone ___, Meeting People ___, Crowds ___, Open Spaces ___,
Fear of Driving ___, Specific Situations/Things (Describe) _____
ADHD: Problems Paying Attention ___, Distractibility ___, Hyperactivity ___, Impulsivity ___
Psychosis: Auditory Hallucinations ___, Visual Hallucinations ___, Others Are Out to Get You ___,
Impaired Reality Testing ___, Things Happen That Usually Refer to You ___,
Someone or Something Outside Controls Your Thinking (Describe) _____

MEDICAL REVIEW OF SYMPTOMS: Fever ___, Chills ___, Sweats ___, Rash ___, Seizures ___,
Dizziness ___, Fainting Spells ___, Head Trauma w/ or w/out (circle) loss consciousness ___,
Headaches (Describe, Including Frequency, Duration) _____→
Loss of Balance ___, Problems Falling ___, Numbness ___, Extremity Weakness ___, Anemia ___,
Loss of Vision ___, Blurred/Double (circle) Vision ___, Eye/Ear (circle) Pain ___, Glaucoma ___,
Ringing in Ears ___, Hearing Loss ___, Hair loss ___, Heat/Cold (Circle) Intolerance ___,
Thyroid Problem (circle High or Low) ___, Increased Thirst ___, Urinary frequency ___,
Blood Sugar High/Low (Circle) ___, Diabetes ___, Chest Pain ___, Palpitations ___, Calf/leg pain ___,
Swelling ___, Heart Disease ___, High Blood Pressure ___, Short of Breath ___, Wheezing ___,
Coughing ___, Asthma ___, Allergies ___, COPD __, Coughing up blood ___, Abdominal Pain ___,
Swallowing Problems ___, Nausea ___, Vomiting ___, Throwing up blood ___, Blood in stool ___,
Heartburn/Reflux ___, Constipation ___, Diarrhea ___, Urinary Pain ___, Urinary Urgency ___,
Urinary Blood ___, PMS ___, Menses Regular/Irregular (Circle) ___, **Breastfeeding ___ until ____,**

Pregnant _____ (Due Date _____), LAST MENSTRUAL PERIOD _____,
Chronic Pain (Describe): _____ →