Health History Form **Name:** _____ **Age:** _____

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. *If you are uncomfortable with any question, do not answer it.*
Thank you!

Main reason for today's visit: _____

Other concerns: _____

Referred by: _____

Height _____ **Most recent weight** _____ **Birthdate:** _____

Given the list of categories below, how much stress is each currently causing you?

	None	Mild Stress	Moderate Stress	Severe Stress
Family				
Friends				
Relationships				
Educational				
Economic				
Occupational				
Housing				
Legal				
Health				

Describe your typical **sleep** pattern: _____

_____

Appetite over the past 2 weeks (refers to desire to eat): □ Good □ Fair □ Poor
Current eating disorder: □ No □ Yes History of eating disorder: □ No □ Yes □ Unsure

Describe your usual breakfast: _____

Dietary restrictions? _____
How do you feel about exercise? _____

Is violence at home a concern for you now? □ No □ Yes
Has violence at home ever been a concern? □ No □ Yes

Have you ever experienced trauma (check if yes)? □Physical □Emotional □Verbal □Sexual □Other
In the past **2 weeks**, have you been bothered by:
Little interest or pleasure in doing things? □**No** □**Yes**
Feeling down, depressed or hopeless? □**No** □**Yes**
Thoughts of hurting yourself or someone else? □**No** □**Yes**
Thoughts things might be better if you weren't here? □**No** □**Yes**

REVIEW OF SYMPTOMS: Please mark any **persistent** symptoms you have had in the **past few months**.

_____ Chronic pain. If yes, where? _____ Beginning when? _____

Concerns/Complaints regarding (circle): eyes / ears / nose / throat / heart / breathing / muscles / bones or joints / gut / blood clots / easy bruising / urinary system / genitals / nervous system / skin

Adult Health History Form **Name:** _____

□ Tremors or worrisome movements
□ Fainting/Dizziness
□ Headache
□ Memory loss
□ Numbness / tingling
□ Unsteady gait
□ Chest pain / discomfort
□ Heart palpitations
□ Shortness of breath or sensation of choking
□ Hot flashes / Night sweats
□ Gender-identity concerns
□ Insomnia or sleep problems
□ Nausea and/or vomiting
□ Weight loss/gain

OB/Gynecologic

□ Pregnant – If yes, Due Date_____
□ Postpartum – Delivery Date _____
□ Perimenopause/Menopause
□ Nursing
□ Infertility
□ Pelvic pain
□ Concern with sexual function
□ Gender affirming surgery/hormones

Psychiatric

□ Suicidal thoughts □ Seeing /Smelling/Hearing/Feeling things that others say aren't there

□ Anxiety/stress □ Irritability □ Frequent crying □ Memory loss □ Difficulty concentrating

□ Depression □ Apathy/Feeling like things don't matter □ Anger □ Intense fear

□ Pre-menstrual symptoms (anxiety, irritability, mood changes)

Other concerns you'd like to discuss: _____

Caffeine intake: _____

Tobacco Use: □ Never □ Not currently □ Yes **How?** □ Cigarettes □ Pipe □ Cigar □ Snuff □ Chew

Former smoker: Quit date:_____ How many years did you smoke?_____ Packs/day?_____

Current smoker: Packs/day:____ # of years:____ **Are you interested in quitting at this time?** _____

Alcohol Use: Do you drink alcohol? □ No □ Yes # of drinks/week: _____
Are you interested in quitting at this time? □ No □ Yes

Drug Use: Do you use marijuana? □ No □ Yes, since age: _____
What kind and in what form? _____
How much & how often? _____
Recreational drugs? □ No □ Yes
History of previous heavy or regular drug use? □ No □ Yes
Please list types, frequency, and when use began _____

Are you interested in quitting at this time? □ No □ Yes
Have you ever received any treatment for substance abuse? □ No □ Yes

Adult Health History Form **Name:** _____

Preferred Pharmacy (include location):_____
Primary care provider: _____
Phone number:_____Address: _____

MEDICATIONS: Please all prescriptions and non-prescription medications, vitamins, birth control pills, herbs, etc. Include dose and frequency. **Use the back of this form if you need more room**.
□ **I TAKE NO MEDICATIONS or SUPPLEMENTS** (including birth control)

_____

_____

Allergies or intolerance to medications or food (include type of reaction) □ **NONE**

_____

Surgical History: Please note any surgeries. List dates and any abnormal finding or complications.
□ **NONE**

_____

Reproductive health plan: *Applies to both male and female clients:
Do you plan to pursue pregnancy within the next year? □ No □ Yes
Method of contraception: _____

OB/GYN HEALTH HISTORY:
Total number of pregnancies: _____ Infertility problems or treatment: _____
Number of live births: _____
Miscarriages or terminations (before 20 weeks): _____
Miscarriages or terminations at or after 20 weeks: _____
Postpartum complications (infection, chronic pain, sick baby, etc): □ No □ Yes
History of a traumatic pregnancy/birth/infertility experience? □ No □ Yes
How often do you get your period?_____ Are they regular? _____
Age at end of periods (menopause):_____
Do you notice your mood changes significantly with your cycle? □ No □ Yes

Have you ever used psychiatric medications? □ No □ Yes (Please list prior meds)

_____

How many times have you been hospitalized for psychiatric reasons? _____

Ever hurt yourself on purpose? □ No □Yes History of suicide attempts? □ No □ Yes

How else have you treated mental health concerns now or in the past?

_____

Have you ever been an abusive toward others? □ No □ Yes
Have you had a history of violent behavior? □ No □ Yes

Adult Health History Form **Name:** _____

Is there something you're hoping to achieve with mental health treatment? _____

_____

PERSONAL MEDICAL HISTORY	Yes	**Comments** (onset, persistent or resolved, major treatments, etc)
Anemia		
Asthma/Breathing problems		
Autoimmune Disorder		
Bladder/Kidney problems		
Cancer		
Chronic Fatigue Syndrome		
Diabetes		(adult, childhood, gestational?)
Fibromyalgia		
Head Injury		Loss of consciousness?
Heart Attack or other heart		
High Blood		
High Cholesterol		
HIV or AIDS		
Gut diseases or disturbances		
Kidney disease		
Liver Disease or Hepatitis		
Migraine headaches		
Seizures/Epilepsy		
Sleep apnea		
Stroke		
Thyroid Disease		(overactive or underactive?)
Alcohol/Drug abuse		
Other addictions		(i.e., gambling, food, sex, etc.)
Depression		
Anxiety		
Obsessive-Compulsive Traits		
Eating Disorder		
Self-harm (cutting, etc.)		
Bipolar disorder/Manic-Depression		
Schizophrenia		
Personality Disorder		
PTSD		
ADHD/ADD		
Autism		

Adult Health History Form **Name:** _____

FAMILY HISTORY	Mother (Biological)	Father (Biological)	Sister(s) #	Brother(s) #	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relatives (*including your children)	Comments
Alzheimer's/Dementia										
Diabetes										
Fibromyalgia										
Heart Problems										
High Blood Pressure										
Thyroid Disease										
Migraine Headaches										
Parkinson's										
Sudden death										
Suicide										
Alcohol/Drug abuse										
Other addictions (i.e., sex, gambling, etc.)										
Depression										
Anxiety										
OCD										
Hormonal mood changes (severe PMS, postpartum depression, anxiety, psychosis, etc.)										
Bipolar disorder/ Manic-Depression										
Schizophrenia										
Personality Disorder										
PTSD										
ADHD/ADD										

Developmental History:

Did you have any delays or difficulties in reaching the following developmental milestones?

□ Walking □Talking □Toilet training □Sleeping alone □Being away from parents □Making friends

Which options below best describe your childhood home atmosphere?

□ Supportive □ Parental fighting □ Parental violence □ Financial difficulties □ Frequent moving □ Other:

Which of the following challenges were experienced during your childhood? (please circle all that apply)

Enuresis (bed wetting)	Tantrums	Property damage
Encopresis (fecal incontinence)	Fire setting	Animal cruelty
Running away from home	Depression	Victim of bullying
Death of a parent/caregiver	Fighting	Engaged in bullying
Separation anxiety	Stealing	Parental divorce

Which of the following best describe problems you may have had in school? (please circle all that apply)

Fighting	School phobia	Truancy	Detentions
Suspensions	Expulsions	School refusal	Class failures
Repetition of grades	Special education	Remedial classes	

Last grade completed or highest degree: _____

SOCIAL HISTORY:

Were you raised by: □ biological parent(s) □ adoptive parent(s) □ Other: _____

Do you have a religion or spiritual practice? □ No □ Yes: _____
Please list previous faiths: _____

□ I don't have guns. If you have guns in your home, are they locked up? □ No □ Yes

Occupation other than parenting (or prior occupation): _____
□ Part-time □ Fulltime □ Unemployed □ Leave of absence □ Retired

Which options below best describes your social situation?

□ Supportive social network
□ Few friends
□ Substance-use based friends
□ No friends
□ Distant from family of origin
□ Family conflict
□ Other:

Sexual orientation: □ Homosexual □ Bisexual □ Pansexual □ Heterosexual □ _____
Transgender? □ No □ Yes Preferred pronoun: he/she/they _____

Relationship status (circle one): single, partnered, married, divorced, widowed, other: _____
Number of times you've been married: _____
Spouse/partner's name: _____
How satisfied are you with your current relationship? _____

Names and ages of children: _____
Who lives at home with you (include pets, friends, temporary longterm guests)? _____
_____

Please note anything else you'd like to include: _____
_____
_____

Thank you for taking the time to fill this out.