AHB Center
FOR BEHAVIORAL HEALTH AND WELLNESS
An Integrative, Compassionate, Personalized Approach

Adult History Form

Please complete this confidential form to help us better understand you and your concerns.

Name: _____ Age: _____

Date of Birth: _____ Gender: _____

Current Employer: _____ Race: _____

Please describe your present concerns**:** Occupation: _____

Family Information

Marital status (check all):

- ☐ single, never married
- ☐ married
- ☐ separated; when:_____
- ☐ divorced; when:_____
- ☐ widowed; when:_____
- ☐ remarried; when: _____

Spouse/Partner's age: _____

Spouse/Partner's occupation: _____

Do you have any children? If so, please list their names and ages below.

Name	Age

Who lives in the home with you? (spouse, significant other, children, step-children, parents, etc.)

Name	Age	Relation to you

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Recent Difficulties

Please check any of the following that have been true for you within the past 6 months:

- ☐ Periods of sadness
- ☐ Feelings of helplessness/hopelessness
- ☐ Feelings of guilt
- ☐ Thoughts of suicide or hurting self
- ☐ Thoughts of hurting others
- ☐ Decreased energy
- ☐ Self-harming behaviors
- ☐ Anxiety/frequent worries
- ☐ Panic Attacks
- ☐ Nightmares
- ☐ Sleep Difficulties
- ☐ Other: _____
- ☐ Memory problems
- ☐ Hallucinations
- ☐ Aggression towards others
- ☐ Feeling irritable/moody/angry
- ☐ Racing thoughts
- ☐ Acting impulsively
- ☐ Feeling disorganized
- ☐ Having difficulty concentrating
- ☐ Feeling restless/hyper
- ☐ Changes in appetite
- ☐ Chronic pain
- ☐ Other: _____

Approximately what time do you go to bed at night? _____ Awake? _____

Please check any of the following events that have happened for you or anyone in the family in the past 6 months.

- ☐ Increase in marital conflict
- ☐ Separation or divorce
- ☐ Remarriage
- ☐ Death in family
- ☐ Loss of job
- ☐ Change in living situation
- ☐ Other _____
- ☐ Trauma or injury
- ☐ Serious illness/hospitalization
- ☐ New baby
- ☐ Jail sentence/legal trouble
- ☐ Job stress
- ☐ Financial stress
- ☐ Other _____

Substance Use History

Do you consume alcohol? ☐ yes ☐ no

If so, about how many drinks per week? _____

Do you currently smoke cigarettes? ☐ yes ☐ no

If so, about how many cigarettes do you smoke per day? _____

Have you used or are you currently using any other substances?

Substance	Age at 1st Use	Current Pattern/Frequency	Last Use

Prior Counseling/Treatment Information

Please list any prior diagnoses:

Diagnosis	Dates (or ages)

Please fill in the following information, regarding past mental health services:

Therapy/Hospitalizations/Community Support	Dates (or ages)

Medical History

Please check any of the following that you have had since birth.

- ☐ Allergies (type: _____)
- ☐ Asthma
- ☐ Chronic pain
- ☐ Diabetes ☐ Type 1 ☐ Type II
- ☐ Eye and/or vision problems
- ☐ Genetic disorder: _____
- ☐ Headaches &/or migraines
- ☐ Head injuries &/or concussions
- ☐ Hearing loss/problems
- ☐ Heart disease/heart attack
- ☐ High blood pressure/hypertension
- ☐ Infections (☐ TB, ☐ CMV, ☐ HIV)
- ☐ Immune disorder: _____
- ☐ Liver disease
- ☐ Multiple sclerosis
- ☐ Renal/Kidney disease
- ☐ Respiratory problems
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Serious injury: _____
- ☐ Thyroid problems ☐ hypo ☐ hyper
- ☐ Surgery: _____
- ☐ Surgery: _____
- ☐ Hospitalization: _____
- ☐ other: _____

What medication(s) have you taken or are now taking?

Medication	Dates	Reason	Effectiveness

Educational History

Please fill in the following information:

School/College/University	Dates (or ages) attended

Describe any academic difficulties, if applicable: _____

Employment History

Employer	Occupation	Dates

Any desired changes in employment situation? _____

Have you served in the military? If yes, please include which branch, years served, number of deployments, and discharge. _____

Hobbies and Interests

Describe special areas of interest or hobbies (e.g., exercise, church, volunteerism, art, reading, sports, etc.).

Activity	How much time per week?	How long participated?

Family Background

If any of your relatives have had any of the following conditions, please check the condition and write that person's relationship to you next to it. By relatives, we mean parents, brothers, sisters, grandparents, aunts, uncles, and cousins on both sides.

	Condition	Relationship to You
☐	Convulsions, seizures, epilepsy	
☐	Speech problems	
☐	Slow development	
☐	Learning problems in reading, writing, math	
☐	Retained/held back in school	
☐	Autism/Aspergers	
☐	Mental retardation	
☐	Hyperactive as a child or (ADD/ADHD) Attention-Deficit/Hyperactivity Disorder	
☐	Depression	
☐	Anxiety	
☐	☐ PTSD ☐ OCD	
☐	Bipolar (manic-depression)	
☐	Eating disorder	
☐	Schizophrenia	
☐	Other mental illness _____	
☐	Suicide attempts	
☐	Alcohol or substance abuse/addiction	
☐	Thyroid disease(hyperthyroidism/hypothyroidism)	
☐	Other _____	

Thank you. We look forward to working with you.