Adult and Child – ADULT FORM
CONFIDENTIAL CLINICAL HISTORY

Name: **Client #:**

Please provide the following information. It will allow your therapist to begin to better understand your current concerns. If you need more space, please use the back of the page.

Learning Disability/ Difficulties?
Yes ☐ / No ☐
Communication Difficulties?
Yes ☐ / No ☐

Are there any cultural, ethnic, or religious/spiritual issues that your therapist should be aware of?

Do you have a shared religious/spiritual community? **Yes ☐ / No ☐**
If yes, is your community important to you? **Yes ☐ / Somewhat ☐ / No ☐**
If yes, is your community a positive support to you? **Yes ☐ / No ☐**

Over the past 2 weeks, how often have you had any problem in the following areas?	Not at all	Several Days	Most Days	Nearly all days
Little interest or pleasure in doing things:	☐	☐	☐	☐
Feeling down, depressed, or hopeless:	☐	☐	☐	☐
Trouble falling asleep, staying asleep, or sleeping too much:	☐	☐	☐	☐
Feeling tired or having little energy:	☐	☐	☐	☐
Poor appetite or overeating:	☐	☐	☐	☐
Feeling bad about yourself – or that you're a failure or have let yourself or your family down:	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television:	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual:	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way:	☐	☐	☐	☐
Difficulty doing work, taking care of things at home or getting along with other people:	☐	☐	☐	☐

Over the past 2 weeks, how often have you had any problem in the following areas?	Not at all	Several Days	Most Days	Nearly all days
Feeling nervous, anxious or on edge:	☐	☐	☐	☐
Not being able to stop or control worrying:	☐	☐	☐	☐
Worrying too much about different things:	☐	☐	☐	☐
Trouble relaxing:	☐	☐	☐	☐
Being so restless that it is hard to sit still:	☐	☐	☐	☐
Becoming easily annoyed or irritable:	☐	☐	☐	☐
Feeling afraid as if something awful might happen:	☐	☐	☐	☐
I drink too much alcohol, abuse prescribed medications, or use illicit drugs:	☐	☐	☐	☐
I bet or gamble more than I should:	☐	☐	☐	☐
I have thoughts of wanting to hurt others:	☐	☐	☐	☐

Nutrition Screen: Please check any of the following that apply:

- **eat less than 3-4 fruit/vegetable & 2 milk product servings daily?** **Yes ☐ / No ☐**
- **have a poor appetite?** **Yes ☐ / No ☐**
- **have food allergies?** **Yes ☐ / No ☐**
- **been recently experiencing nausea/vomiting?** **Yes ☐ / No ☐**
- **have constipation?** **Yes ☐ / No ☐**
- **have diarrhea?** **Yes ☐ / No ☐**
- **weigh excessively more or less for your height?** **Yes ☐ / No ☐**
- **If female, are you currently pregnant?** **Yes ☐ / No ☐**

Minimal Risk = 1-2 Yes Moderate Risk = 3-6 Yes High Risk = 7+ Yes

Housing Category:

Permanent Housing	☐	**Institutional Housing**	☐
Temporary Housing	☐	**Homeless**	☐

Housing Stability:
How long have your lived in your current housing situation?

Less than 6 months	☐	**6 months – 1 year**	☐
1 year – 2 years	☐	**More than 2 years**	☐

Name: Client #:

SUBSTANCE USE HISTORY: NA ☐ Substance:	How Taken:	How Often:	Age First Used:	Date Last Used:
☐ Alcohol				
☐ Marijuana				
☐ Methamphetamine				
☐ Opiates/Heroin				
☐ Benzodiazepines				
☐ Other:				
☐ Other:				
☐ Other:				
☐ Other:				

Have you ever had difficulty with alcohol or other drugs?	Y	N
Does anyone in your family currently have difficulty with alcohol or other drugs?	Y	N
Have you ever used drugs using an IV needle?	Y	N

History of Substance Use Problems (past 12 months; check any that apply):

☐ Failed attempts to stop use	☐ Memory blackouts	☐ Loss of consciousness	☐ Tremors
☐ Morning use	☐ Perceptual Disturbance	☐ Hallucinations	☐ Seizures
☐ Guilt due to excessive use	☐ Legal problems	☐ Incarceration	☐ Financial problems
☐ Criticism by others over use	☐ Missed work	☐ Medical problems	☐ Physical injury
☐ Home responsibilities problems	☐ Arguments or fights	☐ Shared needle use	☐ Problems with family/friends

If in recovery, longest period (number of days) of sobriety in past six months: ____
Have you attended AA/NA 12 Step programs before? ☐ Yes / ☐ No
If worked steps, number completed: ____ Number of AA/NA Meetings Attended in the last 30 days:_________

Past mental health/addictions treatment history: NA ☐

Treatment	Time (Year)	Problem

Indicate family history of mental health, substance abuse, or major medical problems: NA ☐

Family Member Name	Relationship	Problem	Was Treated Yes	Was Treated No	Psychiatric Hospitalization Yes	Psychiatric Hospitalization No
			Y	N	Y	N
			Y	N	Y	N
			Y	N	Y	N

SOCIAL AND LEGAL HISTORY:

Hobbies and leisure activities:

Legal status:

Are you on probation? Yes ☐ / No ☐
Are you on parole? Yes ☐ / No ☐
Are you on deferred prosecution? Yes ☐ / No ☐
Are you being referred for drug court? Yes ☐ / No ☐
Do you have any past or current legal charges? Yes ☐ / No ☐
If yes, explain:
Past or current involvement in DCS/CPS? Yes ☐ / No ☐
If yes, explain:

Name:	Client #:

MEDICAL HISTORY:

What term best describes your overall physical health currently (e.g., excellent, good, fair, poor)?

Please list any allergies:	Weight:
	Height:

If female, are pregnant? Yes ☐ / No ☐ If yes, who is the prenatal care provider? If female, are you breastfeeding? Yes ☐ / No ☐

Do you have health problems in the following areas?	Problem Present? Yes	No	Currently Receiving Treatment? Yes	No
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Cancer/cancer history	☐	☐	☐	☐
Obesity	☐	☐	☐	☐
Emphysema/COPD	☐	☐	☐	☐
Heart problems/cardiovascular disease	☐	☐	☐	☐
Hyperlipidemia/high cholesterol	☐	☐	☐	☐
Smoking/other tobacco related problems	☐	☐	☐	☐
Breathing problems /asthma	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Special nutritional needs	☐	☐	☐	☐
Chronic pain	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐
Hearing/vision/speech problems	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney/bladder problems	☐	☐	☐	☐
Liver/gallbladder problems	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
Epilepsy/seizures/neurological problems	☐	☐	☐	☐
Other, specify:	☐	☐	☐	☐

Have you had the following examinations in the past year:
Physical exam: Yes ☐ / No ☐ Dental Exam: Yes ☐ / No ☐ Visual Exam: Yes ☐ / No ☐ Hearing Exam: Yes ☐ / No ☐

If you have not had a physical examination done within the past year, please make an appointment with your medical provider for one. If you need assistance locating a medical provider, make the office staff aware of your need.

Name of doctor:	Year of last physical exam:	Doctor's phone #:
Name of dentist:	Year of last dental exam:	Dentist's phone #:

Medication Name	Dose	Why Medication is Prescribed	Prescribing Provider

History of injuries, hospitalizations, surgeries:

Do you have an established *Psychiatric Advance Directive* or *Power of Attorney* for your behavioral health care needs? Yes ☐ / No ☐

Pain Screen: Are you currently having physical pain or discomfort? Yes ☐ / No ☐ If yes, pain location? ________________________
Pain Rating: (0=no pain, 10=worst ever) 0 1 2 3 4 5 6 7 8 9 10 When did your pain begin? ____________________________________
What helps relieve your pain? ____________________________ What makes your pain worse? __________________________________

Please check any of the following symptoms you are experiencing:
☐ Night sweats ☐ Chest pain ☐ Foul appearing sputum
☐ Coughing up blood ☐ Cough that won't go away
☐ Fever/Chills

Smoking Status (Please check the box most applicable):

Current Every Day Smoker	☐	Light Tobacco Smoker	☐
Current Some Day Smoker	☐	Never Smoker	☐
Former Smoker	☐	Smoker, Current Status Unknown	☐
Heavy Tobacco Smoker	☐	Unknown if Ever Smoked	☐

	Name:	**Client #:**

Have you ever been told you have Tuberculosis (TB)? Yes ☐ / No ☐	**Impairments/Disabilities (Please check any applicable):**
Have you had a positive TB skin test? Yes ☐ / No ☐	**None Known** ☐ **Blind** ☐ **Mute** ☐
Have you recently been exposed to TB? Yes ☐ / No ☐	**Developmental Disabilities/MR** ☐ **Deaf** ☐ **Non-Ambulatory** ☐
Have you had an abnormal chest x-ray? Yes ☐ / No ☐	**Neurological Impairment** ☐ **Traumatic Brain Injury** ☐
Have you received treatment for TB? Yes ☐ / No ☐	**Learning/Reading Disabilities** ☐ **Hard of Hearing** ☐ **Other** ☐

Housing Category:	**Housing Stability:**
Permanent Housing ☐ **Institutional Housing** ☐	**How long have your lived in your current housing situation?**
Temporary Housing ☐ **Homeless** ☐	**Less than 6 months** ☐ **6 months – 1 year** ☐
	1 year – 2 years ☐ **More than 2 years** ☐

ABUSE/TRAUMA HISTORY:

(Please check all that apply):						
	Current Abuse:	☐ NA	☐ Physical	☐ Emotional	☐ Sexual	☐ Neglect
	Past Abuse:	☐ NA	☐ Physical	☐ Emotional	☐ Sexual	☐ Neglect

While you were growing up, during your first 18 years of life:

Question	
1. Did a parent or other adult in the household **often** … Swear at you, insult you, put you down, or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?	**Yes** ☐ / **No** ☐
2. Did a parent or other adult in the household **often** … Push, grab, slap, or throw something at you? **or** **Ever** hit you so hard that you had marks or were injured?	**Yes** ☐ / **No** ☐
3. Did an adult or person at least 5 years older than you **ever**… Touch or fondle you or have you touch their body in a sexual way? **or** Try to or actually have oral, anal, or vaginal sex with you?	**Yes** ☐ / **No** ☐
4. Did you **often** feel that … No one in your family loved you or thought you were important or special? **or** Your family didn't look out for each other, feel close to each other, or support each other?	**Yes** ☐ / **No** ☐
5. Did you **often** feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	**Yes** ☐ / **No** ☐
6. Were your parents **ever** separated or divorced?	**Yes** ☐ / **No** ☐
7. Was your mother/father or stepmother/stepfather: **Often** pushed, grabbed, slapped, or had something thrown at her? **Or Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **Or Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?	**Yes** ☐ / **No** ☐
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	**Yes** ☐ / **No** ☐
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	**Yes** ☐ / **No** ☐
10. Did a household member go to prison?	**Yes** ☐ / **No** ☐
Total of "Yes" scores:	_______________

Family Financial Support: Food Stamps: ☐Yes ☐No TANF: ☐Yes ☐No Supportive Housing: ☐Yes ☐No

Race:	**Ethnicity:**
☐ White/Caucasian	☐Not Hispanic / Not Latino (White, American Indian, Alaskan Native)
☐ American Indian	☐Other Hispanic, Latino of Central America, etc.
☐ Native/Other Pacific Islander	☐Latino of unknown origin
☐ Other	☐Puerto Rican
☐ Black/African American	☐Mexican
☐ Asian	☐Cuban

CLIENT/CAREGIVER SIGNATURE:	
I verify that I have answered the above questions to the best of my ability and knowledge:	
Client Signature Date	If applicable, Guardian Signature Date
HISTORY REVIEW:	
Clinician comments:	
Clinician Signature Date	Registrar Signature Date