



ADULT- CONFIDENTIAL CLINICAL HISTORY

Name:

Patient ID #:

FULL NAME:	DATE OF BIRTH:	TODAY'S DATE:		
Mailing Address:	City:	State/Zip:		
Social Security Number: Email:	Phone: Age:	Tobacco Use & Smoking: <input type="checkbox"/> Never Smoker <input type="checkbox"/> Light Everyday Smoker <input type="checkbox"/> Everyday Smoker <input type="checkbox"/> Heavy Everyday Smoker <input type="checkbox"/> Smokeless Tobacco (vaping, e-cigarettes, chew) <input type="checkbox"/> Former Smoker		
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ Fluent in English: <input type="checkbox"/> Yes <input type="checkbox"/> No Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Other Ethnicity: <input type="checkbox"/> Not Hispanic / Not Latino (White, American Indian, Alaskan Native) <input type="checkbox"/> Other Hispanic, Latino of Central/South America <input type="checkbox"/> Latino unknown origin <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban Marital Status: <input type="checkbox"/> Married / Living Together <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Dependent Children: <input type="checkbox"/> Yes <input type="checkbox"/> No Are they in need of behavioral health services? <input type="checkbox"/> Yes <input type="checkbox"/> No Do they receive medical care, including immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No Family Financial Support: <input type="checkbox"/> Food Stamps <input type="checkbox"/> TANF Employment: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> In Need of Supported Employment Services	Biological (at Birth) Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male Sexual Orientation: <input type="checkbox"/> Lesbian, gay, homosexual <input type="checkbox"/> Straight of heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other: _____ Gender Identity: <input type="checkbox"/> Identifies as Male <input type="checkbox"/> Identifies as Female <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Transgender Female/ Male-to-Female <input type="checkbox"/> Gender non-conforming (neither exclusively male nor female) <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Additional gender category/ Other: _____ Impairments/Disabilities: <input type="checkbox"/> Learning or Reading Disability <input type="checkbox"/> Communication Difficulties <input type="checkbox"/> Intellectual / Developmental Disabilities <input type="checkbox"/> Heard of Hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Other Physical / Medical	Home Status: <input type="checkbox"/> Permanent Housing <input type="checkbox"/> Living with Others Temporarily (Doubling Up) <input type="checkbox"/> Homeless Living in Streets <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Institutional Housing <input type="checkbox"/> Other: _____ How long have you lived in your current housing situation? <input type="checkbox"/> Less than 6 months <input type="checkbox"/> 6 months – 1 year <input type="checkbox"/> 1 year – 2 years <input type="checkbox"/> More than 2 years Military Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, served in combat <input type="checkbox"/> Immediate family member in military Educational Level: <input type="checkbox"/> Some High School <input type="checkbox"/> High School Graduate (or GED) <input type="checkbox"/> Some College <input type="checkbox"/> College <input type="checkbox"/> Other: _____ Agricultural Worker: <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling asleep, staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself – or that you're a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of wanting to hurt others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADULT- CONFIDENTIAL CLINICAL HISTORY

Name: _____ Patient ID #: _____

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worrying too much about different things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being so restless that it is hard to sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Becoming easily annoyed or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling afraid as if something awful might happen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SUBSTANCE USE HISTORY: NA <input type="checkbox"/>	How Taken:	How Often:	Age First Used:	Date Last Used:
<input type="checkbox"/> Alcohol				
<input type="checkbox"/> Marijuana				
<input type="checkbox"/> Methamphetamine				
<input type="checkbox"/> Crack/Cocaine				
<input type="checkbox"/> Opiates/Heroin				
<input type="checkbox"/> Benzodiazepines				
<input type="checkbox"/> 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
Are you pregnant?				Y N

History of Substance Use Problems (past 12 months; check any that apply):			
<input type="checkbox"/> Failed attempts to stop use	<input type="checkbox"/> Memory blackouts	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Tremors
<input type="checkbox"/> Morning use	<input type="checkbox"/> Perceptual Disturbance	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Seizures
<input type="checkbox"/> Guilt due to excessive use	<input type="checkbox"/> Legal problems	<input type="checkbox"/> Incarceration	<input type="checkbox"/> Financial problems
<input type="checkbox"/> Criticism by others over use	<input type="checkbox"/> Missed work	<input type="checkbox"/> Medical problems	<input type="checkbox"/> Physical injury
<input type="checkbox"/> Home responsibilities problems	<input type="checkbox"/> Arguments or fights	<input type="checkbox"/> Shared needle use	<input type="checkbox"/> 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 Number of AA/NA Meetings Attended in the last 30 days: _____

Health & Life Functioning Screen

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? _____

Tuberculosis Screen: Please check any of the following symptoms you are experiencing: <input type="checkbox"/> Night sweats <input type="checkbox"/> Chest pain <input type="checkbox"/> Foul appearing sputum <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Cough that won't go away <input type="checkbox"/> Fever/Chills Have you ever been told you have Tuberculosis (TB)? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you had a positive TB skin test? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you recently been exposed to TB? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you had an abnormal chest x-ray? Yes <input type="checkbox"/> No <input type="checkbox"/> Have you received treatment for TB? Yes <input type="checkbox"/> No <input type="checkbox"/>	Nutrition Screen: Please check any of the following that apply: Eat less than 3-4 fruit/vegetable & 2 milk product servings daily? Yes <input type="checkbox"/> No <input type="checkbox"/> Have a poor appetite, or decreased food intake Yes <input type="checkbox"/> No <input type="checkbox"/> Have food allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> Been recently experiencing nausea/vomiting? Yes <input type="checkbox"/> No <input type="checkbox"/> Have constipation? Yes <input type="checkbox"/> No <input type="checkbox"/> Have diarrhea? Yes <input type="checkbox"/> No <input type="checkbox"/> Experienced weight loss or gain of 10 pounds or more in the last 3 months? Yes <input type="checkbox"/> No <input type="checkbox"/> Experienced bingeing or induced vomiting?
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Do you have any gender specific treatment needs that your provider should be aware of? _____
 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 No Somewhat If yes, is your community a positive support to you? Yes No

Members in Household: Name	Relationship	Age	Occupation



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MEDICAL INFORMATION:

Current Medications	Dose	Frequency	Why medication is Prescribed	Prescribing Provider

Medication/Vaccine Allergies	Reaction (rash, shock, hives, etc.)

Do you have a primary care provider (Family Medicine, Internal Medicine, or Pediatrician)? Yes No

Name of primary care provider: _____ Phone: _____

Height: _____
Weight: _____

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

Name of doctor: _____ Year of last physical exam: _____ Doctor's phone #: _____

Name of dentist: _____ Year of last dental exam: _____ Dentist's phone #: _____

If Female, Well-Woman's Visit: Yes No

If Female, are you pregnant? Yes No If yes, who is the prenatal care provider? _____

If Female, are you breastfeeding? Yes No

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

Would you like to talk to someone about primary care services at A&C? Yes No

Medical History	Self	Mother's side	Father's side	Comments
ADD/ADHD				
AIDS/HIV				
Abuse/Domestic Violence				
Alcohol Abuse				
Allergies/Hayfever				
Alzheimer's Disease				
Anemia				
Anesthesia Complication				
Anxiety Disorder				
Arthritis				
Asthma				
Autism Spectrum Disorder				
Bipolar Disorder				
Bladder or Kidney Problem				
Blood Diseases				
Blood Transfusion				
Brain Injury				
Breast Cancer				
Breast Problem				
COPD				
Cancer				
Chicken Pox / Shingles				



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Medical History	Self	Mother's side	Father's side	Comments
Congestive Heart Failure				
Constipation				
Coronary Artery Disease				
Depression				
Developmental or Behavioral Disorder				
Dementia				
Depressive Disorder				
Diabetes				
Difficulty Swallowing				
Disorder of the Nervous System				
Diverticulitis				
Ear or Hearing Problems				
Eating Disorder				
Eczema				
Epilepsy				
Endometriosis				
Erectile Dysfunction				
Fibromyalgia				
GERD/Reflux				
GI Problems				
Glaucoma/ Cataracts				
Gout				
Headaches				
Heart Disease/Heart Problems/MI				
Heart Palpitations / Murmur				
Hepatitis				
High Cholesterol				
History of attempted suicide				
Hypercholesterolemia				
Hypertension				
Hyperthyroidism				
Hypothyroidism				
Kidney Disease/Kidney Stones				
Learning Disorder				
Liver Disease / Cirrhosis				
Lung Disease				
MRSA exposure				
Mental Disorder/Illness				
Migraine				
Multiple Sclerosis				
Muscle, Joint, Bone Problems				
Obesity				
Osteoporosis / Penia				
Ovarian Cancer				



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Medical History	Self	Mother's side	Father's side	Comments
Panic Disorder				
Personality Disorder				
Polyps				
Pulmonary Embolism				
Rheumatic diseases / Autoimmune				
Schizophrenia				
Seizures/Epilepsy				
Sexual Abuse				
Skin Problems				
Sleep Disorder				
Stroke / TIA				
Thrombophilias				
Thyroid Disease/Thyroid Problems				
Tourette Syndrome				
Tuberculosis				
Ulcer				
Vision or Eye Problems				
Visual Hallucinations				

Personal Surgical History			
Surgery	Yes	No	Dates/ Comments
Abdominal Surgery			
Adenoid Surgery			
Angioplasty			
Appendix removed (Appendectomy)			
Arthroscopic Surgery			
Back Surgery			
Bilateral Mastectomy			
Brain Surgery			
Breast Biopsy/Breast Surgery			
Caesarean Section			
Cancer Surgery			
Cardiac Surgery			
Cholecystectomy			
Colonoscopy			
Colposcopy			
Cosmetic Surgery			
ENT Surgery			
Ear Tubes			
Eye Surgery			
Gastrointestinal Surgery /Gastric Bypass			
Gyn Surgery			
Hemorrhoidectomy			
Hernia Repair			
Hysteroscopy			
Joint Replacement			
Knee Surgery			
LEEP			



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Surgery	Yes	No	Dates/Comments
Laparoscopy			
Neurosurgery			
Orthopedic Surgery			
Ovarian Cystectomy			
Partial Hysterectomy			
Prostate Surgery			
Reconstructive Surgery			
Rhinoplasty			
Splenectomy			
Thyroid Surgery			
Tonsillectomy			
Total Colectomy			
Total Hysterectomy			
Tubal Ligation			
VP Shunt Placement			
Vasectomy			
Other:			

Preventative Care

Testing	Dates	Testing	Date
Colonoscopy or Stool Blood Testing		PSA Level (Prostate Cancer test)	
Mammograms		Cholesterol Blood tests	
Pelvic Exam/Pap Smear		Hemoglobin A1C/Blood Sugar Testing	

Health Habits

Sexual Activity

Sexually Active Not Currently Sexually Active

Birth Control Method used at present: _____ Have you ever had sex with (circle one)? **Men /Women /Both**

Exercise

Active at least 3 times per week Active at least 1-2 times per week Sedentary (very little or no regular activity)

Activities engaged in: _____ Barriers to exercise: _____

ABUSE/TRAUMA HISTORY: NA

Current Abuse: NA Physical Emotional Exploitation Sexual Neglect

Past Abuse: NA Physical Emotional Exploitation Sexual Neglect

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

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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
6. Were your parents ever separated or divorced?	Yes <input type="checkbox"/> No <input type="checkbox"/>



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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 <input type="checkbox"/> No <input type="checkbox"/>
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Did a household member go to prison?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Total of "Yes" scores: _____	

PATIENT/CAREGIVER SIGNATURE:

I verify that I have answered the above questions to the best of my ability and knowledge:

Patient Signature	Date	If applicable, Guardian Signature	Date
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HISTORY REVIEW:

Clinician comments:

Clinician Signature	Date	Registrar Signature	Date