ADULT & CHILD HEALTH

ADULT- CONFIDENTIAL CLINICAL HISTORY

Name: Patient ID #:

FULL NAME: **DATE OF BIRTH:** **TODAY'S DATE:**

Mailing Address: City: State/Zip:

Social Security Number: Phone: Age:
Email:

Language Preference:
☐ English ☐ Spanish ☐ Other: _____

Fluent in English: ☐ Yes ☐ No

Race:
☐ White/Caucasian
☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander
☐ American Indian
☐ Alaskan Native
☐ Asian
☐ Other

Ethnicity:
☐ Not Hispanic / Not Latino
(White, American Indian, Alaskan Native)
☐ Other Hispanic, Latino of Central/South America
☐ Latino unknown origin
☐ Puerto Rican
☐ Mexican
☐ Cuban

Marital Status:
☐ Married / Living Together ☐ Single
☐ Separated ☐ Divorced ☐ Widowed

Dependent Children: ☐ Yes ☐ No
Are they in need of behavioral health services? ☐ Yes ☐ No
Do they receive medical care, including immunizations?
☐ Yes ☐ No

Family Financial Support: ☐ Food Stamps ☐ TANF

Employment: ☐ Employed ☐ Unemployed
☐ In Need of Supported Employment Services

Biological (at Birth) Sex:
☐ Female ☐ Male

Sexual Orientation:
☐ Lesbian, gay, homosexual
☐ Straight of heterosexual
☐ Bisexual
☐ Don't know
☐ Choose not to disclose
☐ Other: _____

Gender Identity:
☐ Identifies as Male
☐ Identifies as Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/ Male-to-Female
☐ Gender non-conforming (neither exclusively male nor female)
☐ Choose not to disclose
☐ Additional gender category/ Other:_____

Impairments/Disabilities:
☐ Learning or Reading Disability
☐ Communication Difficulties
☐ Intellectual / Developmental Disabilities
☐ Heard of Hearing
☐ Deaf
☐ Blind
☐ Neurological Impairment
☐ Non-ambulatory
☐ Traumatic Brain Injury
☐ Other Physical / Medical

Tobacco Use & Smoking:
☐ Never Smoker
☐ Light Everyday Smoker
☐ Everyday Smoker
☐ Heavy Everyday Smoker
☐ Smokeless Tobacco (vaping, e-cigarettes, chew)
☐ Former Smoker

Home Status:
☐ Permanent Housing
☐ Living with Others Temporarily (Doubling Up)
☐ Homeless Living in Streets
☐ Homeless Shelter
☐ Transitional Housing
☐ Institutional Housing
☐ Other: _____
How long have you lived in your current housing situation?
☐ Less than 6 months
☐ 6 months – 1 year
☐ 1 year – 2 years
☐ More than 2 years

Military Veteran:☐ Yes ☐ No
☐ Yes, served in combat
☐ Immediate family member in military

Educational Level:
☐ Some High School
☐ High School Graduate (or GED)
☐ Some College
☐ College
☐ Other: _____

Agricultural Worker: ☐ 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	☐	☐	☐	☐
Thoughts of wanting to hurt others	☐	☐	☐	☐

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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	☐	☐	☐	☐

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

☐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 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:
☐ Night sweats ☐ Chest pain ☐ Foul appearing sputum
☐ Coughing up blood ☐ Cough that won't go away ☐ Fever/Chills

Have you ever been told you have Tuberculosis (TB)? Yes ☐ No ☐
Have you had a positive TB skin test? Yes ☐ No ☐
Have you recently been exposed to TB? Yes ☐ No ☐
Have you had an abnormal chest x-ray? Yes ☐ No ☐
Have you received treatment for TB? Yes ☐ No ☐

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, or decreased food intake Yes ☐ No ☐
Have food allergies? Yes ☐ No ☐
Been recently experiencing nausea/vomiting? Yes ☐ No ☐
Have constipation? Yes ☐ No ☐
Have diarrhea? Yes ☐ No ☐
Experienced weight loss or gain of 10 pounds or more in the last 3 months? Yes ☐ No ☐
Experienced bingeing or induced vomiting?

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 ☐ 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 ☐

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Name: Patient ID #:

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:	_____

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

HISTORY REVIEW:

Clinician comments:

Clinician Signature Date	Registrar Signature Date