Health History Form - Adult

Note: Do not stress about getting all the details onto this form. This is used as a starting point to make the discussion more beneficial at your appointment. If you cannot answer a question or feel uncomfortable answering a question, please leave it blank.

Legal Name ______________________________ **Birth Date** ______________

What should we call you (preferred name)? ______________________________

Pronouns (check or circle all that apply) she/her/hers he/him/his they/them/theirs ______________

Curent Gender Identity: female male transwoman transman nonbinary ______________

Sex Assigned at Birth: female male intersex list other: ______________

What is the main reason or concern that you are seeking care for?

Past Psychiatric History:

Have you ever been treated for the following?

Anxiety	ADHD	Alcohol problems
Panic Attacks	Academic Struggles	Substance Abuse
Depression	OCD	Behavioral aggression
Sleep issues	Friend conflicts	Psychosis
Relationship issues	Eating Disorder	PTSD
Others (list):		

List all current or previous counselors, with approximate start and end dates of care

Name of provider **Dates**

____

____

____

____

List all previous psychiatrists or APNPs, with approximate start and end dates of care

Name of provider **Dates**

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What non-medication treatments have you tried for mental health symptoms?

Have you ever been hospitalized psychiatrically?

Yes No If yes, when was the last time you were hospitalized: ______________________________

Have you experienced any of the following in the last month?

1)	Feelings of hopelessness or that life is not worth living	Yes	No
2)	Thoughts of hurting yourself	Yes	No
3)	Have a specific plan to hurt yourself	Yes	No
4)	Past suicide attempts ever	Yes	No
5)	Do you self-harm (cutting, burning, etc)?	Yes	No

Past Medical History

What is the name of your primary care provider (PCP) and contact information?

Provider name: ____

Clinic name/address: ____

Clinic phone number: ____

Medical Conditions (Please check or list any medical problems you have experienced.)

☐ Diabetes Type I or II	☐ Cancer / Type:	☐ Heart disease (list):
☐ High blood pressure	☐ High cholesterol	☐ Seizures (list type):
☐ Sleep issues	☐ Thyroid disease	☐ Other:
Additional history:		

Health Habits (check or circle answers)

Tobacco Use:	I smoke everyday	I smoke some days		I am a former smoker	I have never smoked	
On average, how many packs per day currently?	¼	½	1	1.5	2	3
Are you ready to consider quitting?	Yes		No			
Physical Activity: How many days per week of moderate to strenuous exercise? (jogging, running, dancing, swimming, biking, weights) 0 1 2 3 4 5 6 7						
Alcohol Use: How often do you drink alcohol?	Never	Monthly or less	2-4times a month	2-3 times a week	4 or more times a week	
How many alcoholic drinks on a day you are drinking?	1 or 2	3 or4	5 or 6	7 to 9	10 or more	
Recreational Drug Use: Do you use recreational drugs?	No Yes (list specific drugs & frequency):					

Current Medications (Please list and bring the medication bottles with you to your appointment)

Medication	Dosage	Time of day

Previous Medications tried for mental health issues: (check or circle yes or no answers)

Medication	Dosage & timing	Year(s) taken	Helpful?	Side Effects?
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No

Medication Allergies

Medication	Reaction

Social History:

What is your current job/occupation?

What was the last year in school you completed?

Are you married? If yes, how long?

Do you have children? If yes how many?

What do you do to relax or enjoy downtime?

Is there something you would like to get back to doing, that you use to enjoy?

Household members

(List adults first. You can list multiple people on the same line if necessary)

Name | Relationship to patient | Age

____

____

____

____

Family History (Please place a check mark or X in the box)

Condition	Mother	Father	Brother	Sister
Anxiety				
Depression				
ADHD				
Substance Abuse				
OCD				
Thyroid disease				
High blood pressure				
Other mental health (list):				
Other mental health (list):				

Briefly describe any other concerns not mentioned above and your goals for treatment
(ex: a specific goal on improvement of functioning or enjoying a certain aspect of life again)

Return completed form by either:

1) Dropping it off at our office
2) Mailing it back to our office

Address:
Fox Valley Psychiatry LTD
4321 W College Ave, Ste 200,
Appleton, WI 54914