Meridian Youth Psychiatric Center
ADULT HISTORY FORM

INSTRUCTIONS TO PATIENT Please complete this form. It will provide us with important information about you and your needs.

Patient Name _____ **Date** _____

Birthdate: _____ **Age** _____

REASONS FOR SCHEDULING AN APPOINTMENT:

HOUSEHOLD & RELATIONSHIPS

LIST WHO LIVES IN YOUR HOME:

NAME	SEX	AGE	RELATIONSHIP TO YOU

List the occupations of yourself and the other adults who live in the home and how many hours worked outside the home at each job per week. If you are a student, include your time at school plus any jobs:

First Name Occupation Hours worked/week (average)

How long have you lived at this location?

FAMILY / OTHER IMPORTANT RELATIONSHIPS Please note marital status, past marriages, divorces, dating and relationships. Describe degree of support received from family, friends, school, support groups and others.

FAMILY OF ORIGIN: Please describe your relationships with parents/caregivers and brothers/sisters.

PATIENT HEALTH INFORMATION:

ALLERGIES:
Medication Allergies: None ___ Yes: List _____
Other allergies: None ____ Yes : List: _____

PHYSICIANS:
Family MD or Pediatrician: _____
Date of last physical: _____
List any specialists you see:_____

MEDICATIONS: Please list all current medications; both prescription and over the counter taken on a regular basis.

Medication	Dosage	Reason

MEDICAL CONDITIONS: List all medical problems and indicate if past or current:

Condition	Past	Current:

PHYSICAL HANDICAPS OR CHALLENGES: (visual, hearing, motor, physical, etc.) None ____ Yes: Describe:

SLEEP: -Average hours of sleep per night? _____ I sleep: Soundly ___ Fitfully or Restlessly ____
I have bad dreams: Never ___ Occasionally ___ Frequently ___
Do you have concerns about sleep or bedtime? No ___ Yes ___ Describe:

FEMALE HEALTH: Not applicable ___
Is menstruation: Regular ___ painful ___ irregular____ No periods for ____ months
Do you think there are excessive signs of PMS? No ___ Yes ___
Comments:

Number of Pregnancies: _____ Number of Deliveries: _____

NUTRITION: Appetite is usually: Good ___ Excessive ___ Poor ___ Variable ___
My weight over the past few months: has been constant at _____lbs
Gone up by _____lbs
Gone down by ____Lbs
Do you think about your weight and how you look a lot? No ____ Yes ____
Do you have any concerns about your eating patterns or nutrition? No ___ Yes ___
Do you have any difficulty with eating or swallowing? No ____ Yes ____ -
Is there history of vomiting, bingeing or excessive preoccupation with food? No ____ Yes ___
Comments:

SEXUAL: Do you have any sexual or sexuality concerns? No ____ Yes ____ Comments:

TOBACCO: Do you smoke or use Tobacco? No _____ Yes _____
DRUGS & ALCOHOL: Do you use/abuse alcohol? No ___ Yes ____
Do you use/abuse drugs/illegal substances? No ____ Yes ____ Comments:

VIOLENCE / ABUSE: Please describe any physical, verbal, emotional or sexual abuse as the perpetuator, victim or witness. Was the abuse reported to the authorities?

FAMILY MEDICAL HISTORY: List the relationship of the family member and any details if applicable:
List any significant medical problems in the immediate family or close relatives? None ____ Comments:

List any history of genetic illness or developmental illnesses (mental retardation, autism, Huntington's Chorea, Sickle Cell, etc)?: None ____ Comments:

List any family history of emotional problems (nervous breakdowns, depression, obsessive/compulsive, anxiety, schizophrenia, bipolar, etc)? No ____ Comments:

List any family history of suicide? None ____ Comments:

List any family history of substance abuse or addictions? None ____ Comments:

PAST COUNSELING AND PSYCHIATRIC TREATMENT:

List any inpatient hospitalizations: None ___ Comments:

List any partial hospitalizations or Intensive Outpatient Treatment (IOP): None ____ Comments:

List any previous counseling with provider and date: None _____ Comments:

List any medicines used in the past for emotional or behavioral problems: None ____ Comments:

SOCIAL HISTORY:

EDUCATION Provide level of schooling completed, feelings about school, and grades. Please note any discipline problems or learning difficulties. Also, please indicate how you prefer to learn (for example: reading, practicing, talking or watching).

EMPLOYMENT: Provide work history, retirement, terminations, problems on the job, EAP involvement, relationships with co-workers and bosses, shifts, hours per week.

❑ Not Applicable **Military:** □ Yes □ No □ Not Applicable

LEGAL HISTORY: Note any legal difficulties including arrests, nature of charges, convictions, pending charges, guardianship, power of attorney. If you have a probation/parole officer, please provide name and phone number.

CULTURAL : Please describe your ethnic background, religion, community and customs. Please list any cultural issues/practices you would like us to be aware of that would affect your treatment or that you wish to discuss further:

FINANCIAL STATUS: Please describe past and present credit history.

- ☐ Financially secure
- ☐ Finances are a source of stress
- ☐ Currently in debt
- ☐ Plan to file bankruptcy
- ☐ Have filed bankruptcy
- ☐ On Disability
- ☐ On Public Assistance

Comments:

LEISURE ACTIVITIES / TIME WITH OTHERS: Describe your hobbies, interests, social life and volunteer work.

Losses & Changes: What losses, changes or other stressors do you think are affecting you at this time?

OTHER: Is there anything else you would like to tell us?

Form completed by: Name _____ **Date:** _____