# ADULT HISTORY

**Name**_____

Please fill out the following, as completely as possible.

| Birthplace | Religion | Military Service |
|---|---|---|
| How long have you lived in LA area? | School grade completed? | |

Married? ☐ Yes ☐ No How long?

If previously married, please give dates:

Household members:

| Name | Age | Relationship | Occupation/grade |
|---|---|---|---|
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Please list family members who have experienced or had emotional problems, psychiatric illnesses, or/and difficulties with drug or alcohol abuse

| Family member (relationship to you) | Problem | Ongoing | Was the problem resolved? |
|---|---|---|---|
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Describe the Problem(s) that you are seeking help for:

How long have you struggled with this?

Have you ever had psychotherapy or counseling before? ☐ Yes ☐ No

If Yes, when and where?

Have you ever been hospitalized for psychiatric problems? ☐ Yes ☐ No

If Yes, when, where and reason?

Have you ever attempted suicide? ☐ Yes ☐ NO

If Yes, when, where and reason?

**OVER**

Please check the items below that describe your symptoms in the past few weeks or more

| | Never | Rarely | Sometimes | Frequently | Always |
|---|---|---|---|---|---|
| 1. Feel exhausted | | | | | |
| 2. Trouble in my job | | | | | |
| 3. Trouble concentrating | | | | | |
| 4. I feel like crying | | | | | |
| 5. Thoughts of suicide | | | | | |
| 6. It's hard to have a good time | | | | | |
| 7. I feel depressed | | | | | |
| 8. I have trouble making decisions | | | | | |
| 9. Planning to end my life | | | | | |
| 10. I have trouble going to sleep | | | | | |
| 11. It's hard to stay asleep | | | | | |
| 12. I drink too much | | | | | |
| 13. I use drugs too much | | | | | |
| 14. I think about harming others | | | | | |
| 15. Experiencing headaches or dizziness | | | | | |
| 16. I binge eat | | | | | |
| 17. I worry about my weight | | | | | |
| 18. Stomach trouble | | | | | |
| 19. Strange experiences | | | | | |
| 20. My heart beats fast | | | | | |
| 21. I imagine terrifying things | | | | | |
| 22. Panicky feelings | | | | | |
| 23. Uncontrollable worrying | | | | | |
| 24. I fear I may harm someone | | | | | |
| 25. I fear things I shouldn't | | | | | |
| 26. I feel apart from people | | | | | |
| 27. It's hard for me to make friends | | | | | |
| 28. I have trouble keeping friends | | | | | |
| 29. I see or hear things other people don't | | | | | |
| 30. My mind is not as clear as it was | | | | | |
| 31. People dislike me | | | | | |
| 32. I get so nervous I can't move | | | | | |
| 33. I'm afraid to go out alone | | | | | |
| 34. I'm afraid to be alone | | | | | |

MEDICAL HISTORY

When was your last physical?_____

What medications are you taking?

| Medication | Frequency | Dosage |
|---|---|---|
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| | | |

Have you had any problems with medications? _____

_____

Recent unplanned weight ☐ gain ☐ loss How much? _____

What medical problems do you have? _____

_____

Have you had any surgeries? ☐ Yes ☐ No

If yes, please provide dates _____

_____

Have you had any legal difficulties? ☐ Yes ☐ No

If yes, please describe _____

_____

_____ _____

Signature Date