Flaton ADDept Center

ADULT HEALTH HISTORY – Complete all items honestly

ALL ANSWERS ARE CONFIDENTIAL

Name ____ Birth Date ________________ Date _________________

What is your reason for coming to see us? ____

____

____

Symptoms: Check all symptoms that you currently have or have had this year

[ ] Anger
[ ] Fears and Phobias
[ ] Obsessive Thinking
[ ] Anxiety
[ ] Flashbacks
[ ] Procrastination
[ ] Aggressive Behavior
[ ] Headaches
[ ] Perfectionism
[ ] Attention Problems
[ ] Impulsive Behavior
[ ] Panic
[ ] Compulsiveness
[ ] Irritability
[ ] Stress
[ ] Depression
[ ] Learning Problems
[ ] Seasonal Changes
[ ] Disorganization
[ ] Moodiness
[ ] Worry
[ ] Eating Problems
[ ] Negativity
[ ] Other

Physical Symptoms: Check all symptoms that you currently have or have had this year

[ ] Asthma
[ ] Dizziness
[ ] Muscle Pain
[ ] Bleeding
[ ] Fevers
[ ] Numbness
[ ] Hearing Problems
[ ] Passing Out
[ ] Bruising
[ ] High Blood Pressure
[ ] Seizures
[ ] Chest Pain
[ ] Stomach Pains
[ ] Involuntary Movements
[ ] Constipation
[ ] Irregular Heart Beat
[ ] Visual Changes
[ ] Diarrhea
[ ] Joint Pain
[ ] Weakness
[ ] Other

Conditions: Please list all conditions that you have had ____

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____

Medications: Please list all prescription and non-prescription medications that you take

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Occupation: ____

Primary Sources of Stress in Occupation, if any: ____

____

____

Health Habits:

Do you regularly exercise? [ ] yes, what exercise: ____ [ ] no

Do you get a regular check up? [ ] yes [ ] no

Do you consume:

Alcohol? [ ] yes, ____________#/week [ ] no
Tobacco? [ ] yes, ____________#/week [ ] no
Caffeine? [ ] yes, ____________#/week [ ] no
Drugs? [ ] yes, ____________#/week [ ] no

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Family History: Please check any conditions present in a blood relative

[ ] Alcoholism
[ ] Abuse
[ ] Anxiety
[ ] Bipolar Disorder
[ ] Depression
[ ] Psychosis
[ ] Suicide
[ ] Trauma
[ ] Violence
[ ] Obsessive Compulsive Disorder
[ ] Attention Deficit Disorder
[ ] Other ________________________

Family Health Status:	Age	State of Health	Quality of Relationship
Father			
Mother			
Sibling			
Sibling			

Treatment History

Hospitalizations: ____

____

____

Prior psychotherapy: ____

____

____

Prior psychiatric care: ____

____

____

Serious illness or injury: ____

____

____

Surgeries: ____

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