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Adult History Form

Name: ____ **Today's Date:** ________________

Date of Birth: ___________ **Age:** _________ **Biological Sex:** ________________________

Identified Gender (if different than sex): ____

Preferred Gender Pronouns (if applicable): ____

Partner/Relationship Status:______________________ **Race/Ethnicity:** _______________

Religious/Spiritual Affiliation (if applicable): _______________________________________

Other Important Cultural Information: ____

Presenting Problem:

Reasons for seeking services:

Please list current symptoms:

Mental Health History:

How long have you been dealing with these concerns?:

Please list past outpatient therapy you may have received:
(Name of therapist/length of time in therapy/type of work completed/past diagnoses)

Please list past inpatient mental health hospitalization you may have received:
(Name of hospital/location/length of stay/age of hospitalization/reason for hospitalization)

Please list past and current medications you have been prescribed/are using:

Medication name	Dosage	Reason for med.	Taking as prescribed? (Y/N)

Educational History:

Highest level of education/name of school:

Please list/describe any trouble you may have experienced in school (academic or behavioral)?:

Employment History:

Occupation:

Place of employment:

Have you ever been fired from a position? Y/N

If Yes, what were the circumstances?:

Military Status (circle all that apply)

Branch of military served:

Currently enlisted

Reserves

Veteran-Discharge Status/Reason for discharge:

- Honorable
- Other Than Honorable Conditions
- Bad Conduct
- Dishonorable
- Officer
- Entry-level separation
- Medical
- Administrative

Tours of duty completed:

Social Functioning:

Who do you rely on for support?:

What do you do for fun?:

Medical History:

Please list any medical conditions you have and rate how well managed they are (good, fair, poor):

Please list any surgeries you may have had:

Please list any hospitalizations you may have had for a medical condition/length of stay:

Family of Origin History:
Place of birth:

By whom were you raised?:

Relationships with family members (e.g. good, fair, poor, abusive, no contact):
(QoR=Quality of Relationship)

Name	Relationship	Past QoR	Current QoR	Mental Health Symptoms/Diagnoses

Please list other family members not listed above who may have had diagnosed or undiagnosed mental health conditions:

Current Family & Living Conditions:
Please list who currently lives with you and the quality of those relationships:

Sexual History:
Please indicate the last time you were sexually active (with a partner and alone):

Age at first sexual encounter:

Attracted to males/females/both/other:
Please circle/highlight any of the following sexual concerns:
Low desire *Low arousal* *Difficulty reaching orgasm* *Premature/rapid ejaculation*

Delayed ejaculation *Pain with vaginal penetration* *Pain with anal penetration*

Discrepancies in level of sexual desire with your partner *Sexual avoidance*

Feelings of embarrassment talking about sex with a partner

Are there any other sexual concerns you might want to discuss with Dr. Hanzlik? Y/N
(Feel free to write those below or wait until face-to-face session to discuss)

Trauma History

The purpose of this section is for me to have a better understanding if there have been past experiences of trauma on your part that may be affecting you in the present. We can discuss this section in more detail when we meet in person.

Please circle/highlight any of the following you may have experienced:

Physical abuse *Emotional/verbal abuse* *Sexual abuse*

Witnessing violence (including domestic violence) *Bullying*

Confusing experiences/boundary violations *Peer rejection*

Natural disasters *Loss of a parent or other important caregiver*

Substance Use:

Please check the following substances you have used in the past and currently:

	Past	**Current**
Alcohol		
Wine		
Liquor		
Beer		
Marijuana (any form)		
Cocaine		
Crack Cocaine		
Hallucinogens		
Inhalants		
"Club Drugs" (i.e. Ecstasy)		
Heroin		
Prescription Drugs (not as prescribed)		
Stimulants		
Tobacco		
Caffeine		
Other		

Has anyone ever expressed concern that you might need to cut back on your use? (Y/N/Who/Circumstances):

If so, have you felt annoyed/irritated and has it caused conflict?:

Please list any prior treatment for drug or alcohol use:
(Inpatient/Intensive Outpatient/Educational/Detox/Date/Location):

Legal History:

Charge	Date of Arrest	Incarcerated (Y/N)	Pending Case (Y/N)

Other Important Information Dr. Hanzlik Should Know About:

Goals for therapy (*if applicable*):

Short Term	Long Term
1.	1.
2.	2.
3.	3.