ADULT CONFIDENTIAL HISTORY
INDEPENDENT BEHAVIORAL HEALTH GROUP

Patient Name: ______________________________ Age: ___________

DOB: ______/______/______ Social Security Number: __________/______/__________

Marital status: __ Married __Never Married __Remarried __Divorced __Widowed __Separated

1. **CHIEF COMPLAINTS & PRESENTING PROBLEMS**

__ Depressed mood __ Worthlessness __Obsessive/Compulsive __ Hyperactivity
__Concomitant Medical Condition __ Depressed Energy __ Guilt __ Elevated Mood
__Dissociative States __ Marital Conflicts __ Somatic Complaints __ Anxiousness
__ Irritability __ Oppositionist __ Family Problems __ Hopelessness __ Panic Attacks
__ Impulsiveness __ Grief __ Work Problems __ Sleep Disturbance __ Anger __ Eating Disturbance __ Substance Use __ School Problems
__ Other(specify):____

In your own words, please state why you need professional assistance:

____

____

____

Symptoms have been present for: ___1-6 months ___7-11 months ___12 or more months

EDUCATION/OCCUPATION

Highest grade or degree completed: ___________________Year _________________

Additionaleducationalinformation____

CurrentOccupation/Employment____

FAMILY

Spouse/Significant Other (age, education, occupation, years married)

____

If Married Before, years of marriage, divorces, deaths ___________________________________

Children: Name	AGE	Biological	Lives with you
_____________________________	________	_________	**Yes or No**
_____________________________	________	_________	**Yes or No**
_____________________________	________	_________	**Yes or No**
_____________________________	________	_________	**Yes or No**

Other Family Members:	Quality of Relationship	AGE	Living

Patient Name____ DOB_______________

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MOM	______________________________	________	**Yes or No**
DAD	______________________________	________	**Yes or No**
M GRANDMOTHER	______________________________	________	**Yes or No**
M GRANDFATHER	_____________________________	________	**Yes or No**
P GRANDMOTHER	______________________________	________	**Yes or No**
P-GRANDFATHER	______________________________	________	**Yes or No**
______________	______________________________	________	**Yes or No**
______________	______________________________	________	**Yes or No**
______________	______________________________	________	**Yes or No**

FAMILY HISTORY

Have any family members been treated for emotional or substance abuse problems? If so, who?

____
____

Family History of Alcohol Use, substance use or abuse. Include Problem Drinking and Drug Abuse, consequences of use, years used:

____
____

Have any immediate or parental family members experienced problems like the ones for which you are requesting professional assistance?

____

PREVIOUS MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT: *(Specify dates, reasons for seeking treatment, response to treatment)*

What Is Your Average Number of Alcoholic Drinks Per Week?

____

Do you use substances other than alcohol? If so, what and how often?

____

Has the patient been admitted to hospital or residential treatment facility for treatment (including Day Treatment, IOP, and Partial Day Hospitalization) of substance abuse or mental health condition within the last 12 months? ___ Yes ___ Denies

If "Yes," identify the facility, location and date of admission.

Facility: ____

Address: ____

Patient Name____ DOB______________

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Date of Admission: ____

SUBSTANCE ABUSE: *(Check all that apply currently or in the past)*

__ Blackouts __ Loss of control __ Family/Job/Legal Problems __ Increased Tolerance

__ Using Illegal Substances __ Preoccupation __ Previous SA Treatment
__ Medical Marijuana Card __ Inability to Stay Free of Substance(s)

__ Previous/Current withdrawal __ Pt/Others Concerned about pt.'s substance use

___Denies all indicators

OTHER ADDICTIVE BEHAVIOR PATTERNS: *(check all that apply currently or in the past)*

__ Smoking/Nicotine __ Compulsive Exercising __ Theft/Shoplifting __ Sexual/Pornography
__ Gambling __Compulsive Eating/Dieting __ Internet/Video Games __ Other:

___ Denies all indicators

HOMICIDE/SUICIDE:

1. Does the patient have a history of any suicidal or violent and assaultive thoughts, urges, plans, or behaviors? **Yes or No**

If yes, provide dates and description: ____

____

2. Is the patient currently having any suicidal or homicidal thoughts, urges, or substance abuse problems? **Yes or No**

If yes, provide symptoms, outcomes, etc.: ____

____

3. Please answer the following accordingly.

Chronic pain or recent diagnosis of life-threatening/life-altering illness	**Yes or No**
Significant losses such as financial reversal or stress; loss of job/relationship	**Yes or No**
Access to means (i.e.: gun ownership, potentially lethal medications, etc.)	**Yes or No**
Major Psychological trauma/ challenge/ life event	**Yes or No**
Substance Abuse	**Yes or No**
Chronic use of opioids	**Yes or No**
Significant legal problems	**Yes or No**
Living alone	**Yes or No**

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Serious Mood Disorder **Yes or No**
Family history of suicide **Yes or No**

EXPLAIN any YES ABOVE:

____
____
____

HISTORY OF MEDICAL HOSPITALIZATIONS/SURGERIES OR MAJOR ILLNESS RESULTING IN HOSPITALIZATION **___ Denies previous medical hospitalizations**

If hospitalized, for what and when: ____

____

CURRENT MEDICAL CONDITIONS **___ Denies any current medical problems**

Elaborate on any current medical conditions: _____________________________________

____

CURRENT MEDICATIONS:

____
____

Accidents or Injuries (Include Dates)

____
____

Disabilities, Limitations or Ailments at this time

____
____

Are You Experiencing Any Pain? YES NO
AreaofPain____
____

Name and address of primary care physician

____

When were you last examined by physician? ____

HEALTH AND LIFESTYLE:

Sleep Habits: ____

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Eating Habits: ____
Alcohol Consumption: ____

Caffeine/Nicotine Consumption: ____

Exercise: ____

Social History:

Family of Origin (*include quality of relationships & socioeconomic status)* : __________________

____

____

Current family *(include quality of relationships & socioeconomic status)*: ___________________

____

____

____

Current living environment *(include living arrangements, i.e., lives alone, apartment, multiple family, homeless)*: ____

____

Significant financial issues: ____

____

____

Peer relationship history *(include ability to participate with peers in programs and social activities)*: ____

____

Sexual history *(include sexual orientation and history of abuse, either abuser or abused, etc.)*:

____

____

Cultural history *(social/cultural influences on identity/value/beliefs)*:

____

Patient Name____ DOB______________

____

Strengths/ Resources: ____

____

Leisure/ Recreational Interests/ Hobbies: ____

____

Religious/ Spiritual *(include religious beliefs, church attendance, spiritual practices and awareness of spiritual needs)*: ____

____

Any academic/behavioral problems during your school career?____

Have you ever been in trouble with the law?(if yes, state incidents and dates)____

Have You Ever Served in The Military? (if yes, state types of service and dates)
____

ALLERGIES:

____
____
____
____

Signature Patient/Guardian: ___________________________________ Date: _______________

Signature of Clinician: ____ Date: ______________

Signature of Psychiatrist: _______________________________________ Date: _____________