LINDEN
BEHAVIORAL PEDIATRICS
Exceptional Care for Youth & Families

ADULT HISTORY FORM
(All information on this form is strictly confidential)

Please complete all information on this form and submit online or bring it to the first visit. Thank you!

Name_____ Date_____

Date of Birth _____

Address _____

_____

Primary Phone _____ Secondary Phone_____

Primary Care Physician_____ Phone _____

Specialty Care Physican_____ Phone _____

Specialty Care Physican_____ Phone _____

Emergency Contact _____ Phone _____

What are the problem(s) you are seeking help for?

_____

_____

_____

_____

What are your treatment goals?

_____

_____

_____

_____

Current Symptoms Checklist: (check once for any symptom present and twice for major symptoms)

Medical History:

Current medical problems:_____

_____

_____

Past medical problems, non-psychiatric hospitalization or surgeries _____

_____

List ALL current prescription medications and how often you take them, including vitamins and supplements:

Medication Name Dosage Estimated Start Date

_____
_____
_____
_____

For women only:

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

How many times have you been pregnant? _____ How many live births? _____

Have you begun menopause? ( ) Yes ( ) No If no, are your periods normal? ( ) Yes ( ) No

Please describe any concerns related to your reproductive health at this time? _____
_____
_____

Psychiatric History:

Have you ever sought treatment for a mental health symptom? ( ) Yes ( ) No

Outpatient Treatment ( ) Yes ( ) No

If yes, please describe when, by whom, the nature of treatment and whether it was helpful.

_____
_____
_____
_____

Psychiatric Hospitalization ( ) Yes ( ) No

If yes, describe for what reason, when and where.

Reason Date(s) Hospitalized Where

_____
_____
_____
_____

Past Psychiatric Medications: Please list any psychiatric medications that you have taken, including dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

_____
_____
_____
_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for: (Check all that apply)

___ Bipolar disorder
___ Depression
___ Anxiety
___ Alcohol abuse
___ Other substance abuse
___ Violence
___ Schizophrenia
___ Post-traumatic stress
___ Personality disorder
___ Anger
___ Suicide

If yes, who had what problems? _____
_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No

If yes, who was treated and what medications and how effective was the treatment? _____
_____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week? _____ How much time each day? _____

What kind of exercise do you do? _____
_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____
_____
_____

How many days per week do you drink any alcohol? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____
_____
_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History: How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? **( )** Yes **( )** No How many packs per day on average? _____ How many years? _____
In the past? **( )** Yes ( ) No How many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? **( )** Yes **( )** No. In the past? **( )** Yes **( )** No
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up? _____
List your siblings and their ages: _____
_____
_____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with? _____
Briefly describe your parents and your relationship with them:_____
_____
_____

How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who, when, and how? _____
_____
_____
_____
_____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No
Please describe when, where and by whom. _____
_____
_____

Educational History:
Did you attend college? _____ If so, where? _____
What degree(s) have you attained?_____
Occupational History:
Are you currently: ( ) Working ( ) Not working by choice ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Separated/Divorced ( ) Single ( ) Widowed

How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse/significant other's occupation? _____

Describe your relationship with your spouse/significant other:

_____

_____

_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

How long in each marriage? _____

Do you have children? ( ) Yes ( ) No. If yes, list ages and gender _____

_____

Describe your relationship with your children: _____

_____

_____

List everyone who currently lives with you: _____

_____

_____

_____

Legal:

Have you ever been arrested? _____ If yes, when and why? _____

Do you have any pending legal problems and if so, what? _____

_____

Spiritual life:

How would you describe your spiritual health? _____

_____

_____

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, which one? _____ What is your level of your involvement?
_____
Do you attend church a church? ( ) Yes ( ) No
If yes, which one? _____ How often? _____
Do you find comfort and support through faith? _____
_____

Thank you for taking the time to complete this form so that LBP can best assist you.