Northland
HealthCenters

Adult New Client-Medical and Behavioral Health History

Name_____ Preferred Name_____

Today's Date_____ Date of Birth:_____ Age: _____ Ethnicity _____

Marital Status_____

- ❑ Male
- ❑ Female
- ❑ Transgender
- ❑ Other_____

Have you been referred to this office by anyone?_____

Who is your primary care _____

Reasons for seeking mental health services:_____

_____

_____

_____

_____

What has been stressing you of late (e.g.family, job, recent loss of loved ones, finances)?

_____

_____

_____

_____

How long this has been going on?

_____

_____

What does make your condition better?

_____

_____

What does make your condition worse?

_____

_____

Are you having any of the following problems, please circle:

Depression	Worrying excessively	Sexual abuse offender
Loss of interest in activities	Having tense muscle	Domestic violence victim
Feeling hopeless, worthless or hopeless	So anxious you feel you cannot rest	Domestic violence offender
Poor energy	Having panic attacks	Sexual orientation problems
Poor self-esteem	Nightmares	Hearing voices
Change in appetite	Feeling awkward in public	Seeing things
Fatigue	Thought that replay	Feelings people were trying to watch or harm you
Poor focus	Repetitive or compulsive behaviors	Concerns about eating too much
Sleeping problems	Obsessions	Concerns about eating too much (binging)
Thoughts of not being alive	Phobias or fears	Memory problems
Periods of euphoria or unusually good mood	Grunts, tics or jerks	Getting lost easily
Having very high energy for no reason	Problems with concentration	Forgetting how to do tasks
Going days without needing to sleep	Hyperactivity	Problems finding words
Thoughts racing	Legal problems	Problems caring for yourself
Talking to fast	shoplifting/stealing	Abortion issues
Acting impulsively (spending money, being hypersexual, etc)	Lying	Adoption problems
Substance use issues	Grief or loss issues	Control/anger issues
Family/Marital conflict	Suicidal thoughts/gestures	Gambling problems
Significant medical issues	Verbal/emotional/physical/ Sexual victim	other?

PSYCHIATRIC HISTORY:

Any Current or Past Psychiatric Medications:

Medication Name	Age when used	Dose	Reason	Effectiveness

Have you ever seen a psychiatrist before? Who? _____

When?_____Where?_____

_____

Have you ever seen a therapist/counselor before? Who? _____

When?_____Where?_____

_____

Have you ever been in a psychiatric hospital before? _____

Why?_____

When? _____ How long?_____

Have you seen an addiction counselor before? _____

With what mental have disorders have you been diagnosed and when? _____

_____

_____

What treatment have you received for listed diagnosis by you? _____

_____

_____

_____

Have you ever tried or thought to harm yourself? Explain_____

_____

Have you ever harmed yourself by scratching yourself, hitting, cutting or burning yourself?

_____

_____

Do you have any family history of suicide?_____

_____

_____

SOCIAL HISTORY:
Please check any of the following that apply to your childhood or adolescence.

Unhappy Childhood _____ Family Problems _____ School Problems _____
Emotional/Behavioral Problems _____ Alcohol Abuse _____ Drug Abuse _____ Medical Problems _____
Legal Problems _____ Physical Abuse _____ Sexual Abuse _____ Emotional Abuse _____
Other _____

Where were you born? _____
Who raised you and where?_____
Was any of your parents absent from your home while growing up, explain?_____
_____
_____

Describe your experience growing up and relationships with loved ones_____
_____
_____

Have you ever been arrested?_____
_____

Do you have any current legal problems or history of legal problems?_____
_____
_____

How many times married**?** _____ Current partner's name: _____
How long have you been in your last relationship? _____
Why did your previous relationship ended and how long it lasted? _____
_____
_____

How many children do you have? _____

Name	Age	Gender	Living with you? Yes or no

What are your hobbies?_____
_____
_____

What are your strengths? _____
_____
_____

What are your weaknesses?_____
_____
_____

What are your religious/spiritual beliefs? Do you belong to a church? _____
_____
_____

Education:
What is that last grade you completed? _____
What is your highest degree awarded?_ _____
Please describe; the types of grades you received: _____
Were you ever held back a grade or promoted an extra grade? _____
Did you take any special education classes? _____
Were you ever diagnosed with a learning disability or ADHD? _____
_____
Were you bullied? How did you get along with other children; did you have friends at school?
_____
_____
_____

Employment:
Occupation: _____
How long at job? _____Job satisfaction_____
Your previous jobs in the last 5 years_____
_____
_____
If unemployed, why and how long? _____
_____
How many jobs have you been fired from? _____
Have you ever served in the military service? (describe branch, type of discharge, combat experience?)_____
_____
_____

Sexual History:
What is your sexual identity: _____
History of sexual abuse _____
Number of sexual partners in the last 5 years? _____
Are you sexually active?_____
Are you on any birth control method? _____
Have you ever been HIV tested?_____

Substance Abuse History:

Substance	Age	Amount used	How often now	How much now
Alcohol				
Cigarettes/nicotine products				
Marijuana				
Crystal meth				
Cocaine/crack				
Heroin				
Diet pills				
Acid				
Downers				
Prescription pills				
Over-the counter-medications				

Have you ever received treatment for drug abuse?_____ How many times?_____
Treatment One When? _____ Where?_____ How long clean after?_____
Treatment Two When? _____ Where?_____ How long clean after?_____
Treatment Three When? _____ Where?_____ How long clean after?_____

Your general health history: Circle which apply:

Cerebral palsy	seizures	fainting
Loss of consciousness	Head injury	Hearing problems
Vision problems	Heart disease	Heart murmur
Rheumatic fever	Heart surgery	Blood transfusion
anemia/sickle cell disease	Excessive bleeding	Excessive bruising
Prone to infections	Immune system disorder	AIDS/HIV
pneumonia	Cystic fibrosis	asthma
Difficulty breathing	Stomach or intestinal problems	hepatitis
jaundice	UTI	Bladder or kidney problems
Bed wetting	Possibly pregnant	Diabetes
Thyroid/glandular disorder	Weight loss/gain	Skin problems

Cold sores	Canker sores	Limit use of arms/legs
arthritis/joint problems	Muscle weakness	Others

If you circled any of the above please explain:_____

_____

_____

_____

Have you ever had any surgeries? Have you been hospitalized for non-psychiatric reason?

_____

_____

_____

Do you have any allergies to medications, food or environment?

_____

_____

_____

Any current other medications (e.g. hypertension, diabetes, thyroid disorder, etc.). Please, provide names, dosages and reason for taking the medications.

_____

_____

_____

Are you taking any over-the-counter medications, herbs? What are you taking them for?

_____

_____

_____

FAMILY HISTORY:

Family History of Mental Illness

Disorder	Relative(s)	Brief Description
Alcohol or other substances		
Anxiety,phobias, obsession		
Autism/Asperger's		
Behavioral problem/conduct/disorder/criminal behavior		
Conflict with family or others		
Depression		
Learning disorders or		

intellectual difficulties		
Mania/bipolar disorder		
Attention-deficit/hyperactivity disorder		
Psychosis/schizophrenia		
Seizures/epilepsy/traumatic brain injury		
Suicide or suicide attempt/ psychiatric hospitalization		
Tics/Tourette's		
Others		

Family Medical History

Anyone in the Family Have:

Disorder	Who
Diabetes	
High Blood Pressure	
Heart Disease	
Tuberculosis	
Respiratory	
Hepatitis	
Seizure Disorder	
Cancer	
Kidney Disease	
Thyroid Disease	
Blood Disorder	
Arthritis	
Legal Problems	
Dementia	
Strokes or others	

If you would like to add anything, please do so in the space below:

Thank you for completing this questionnaire. We hope that the information you have provided will help us to better understand your concerns/problems and provide you with the best the best care.

Northland Health Centers