ADULT HEALTH HISTORY

Name of Patient ______________________________ Date ______________

Gender __________ Date of Birth __________ Age _____ Occupation ______________________

Address ____

Address ____

Phone Numbers: Home __________________ Work: __________________ Cell: __________________

Emergency Contact Name: ____________________________ Contact Number: __________________

Email: ____

FAMILY HISTORY

Family history can often be helpful in understanding an individual's problems.

Mother's highest education level: ____

Father's highest education level: ____

Please check any box that applies:

Has anyone in the family had:	Siblings	Parents	Extended Family
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Alcohol/drug problems			
Anxiety, depression, other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			

Please list all family members (in or out of house) and other people currently in the house:

Name	Relationship	Age	Currently in House?

Parents are: ☐ Married ☐ Living together ☐ Divorced ☐ Separated ☐ Widowed

BIRTH HISTORY

Do you have any information with regard to your birth history?

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DEVELOPMENTAL HISTORY

Do you have any information with regard to your infant health status?
For example, were you hospitalized, or had any serious health issues?

MEDICAL HISTORY

Are you regularly checked by the following:

☐ Medical Doctor ☐ Chiropractor ☐ Osteopath ☐ Naturopath ☐ Dentist ☐ Other

Do you have braces on your teeth, or have you had them in the past? ☐ Yes ☐ No

Do you have any amalgam fillings? How many? __________ ☐ Yes ☐ No

Do you complain of any ongoing physical pains? ☐ Yes ☐ No
(headaches, stomach aches, muscle/joint aches, or growing pains)

Do you suffer from dry skin, dandruff, hard skin on elbows, bumps on the outside of the arms, cracked heels, excessive thirst/urination? ☐ Yes ☐ No

Please list all of your medical and/or psychological diagnoses, past and present:

Please list all current prescription medications:

Are you exposed to a toxic environment (including passive smoking or industrial chemicals)? ☐ Yes ☐ No

Have you had any serious falls, physical traumas, or physical injuries? ☐ Yes ☐ No
Please list:

Have you ever been involved in a motor vehicle accident? ☐ Yes ☐ No
Please list:

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Has your hearing ever been tested? ☐ Yes ☐ No

When was your last hearing test? ______________________________

Has your vision been tested? ☐ Yes ☐ No

When did you last visit the optometrist? ______________________________

Do you wear glasses/contact lenses? ☐ Yes ☐ No

Have you been hospitalized? ☐ Yes ☐ No

If Yes, for what?

Have you had any surgeries? ☐ Yes ☐ No

If Yes, what reason?

Have you had any surgeries recommended to you that have not been performed? ☐ Yes ☐ No

If Yes, for what?

Have you had prior psychotherapy or counseling? ☐ Yes ☐ No

If Yes, for what issue?

BEHAVIOR/MENTAL HEALTH

On a scale of 1 to 10, describe your stress level

Personal ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Occupational ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe any sports or activities you are involved in.

Indicate the number of hours a week of "screen time" you use:

Computer __________ Smart Device (phone, iPad, etc.) __________

Computer games (DS, etc.) __________ Television __________

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Describe your family relationships; with parents and siblings.

Do you have many friends? ____

Do you excel at, or struggle to build relationships with your peers? ☐ Excel ☐ Struggle ☐ Neither

If you struggle, why do you think that is?

What problems do you have with peers, if any?

☐ None
☐ Being physically attacked
☐ Being bullied
☐ Bragging to peers
☐ Rejected by peers
☐ Jealous of peers
☐ Being teased
☐ Overly physically affectionate

Do you have self-esteem issues? ☐ Yes ☐ No

Do you feel that you exhibit any of the following symptoms more often than is typical? (Please check any that apply)

☐ Often touchy/easily annoyed
☐ Often defies rules
☐ Often angry/resentful
☐ Often argues with adults
☐ Often loses temper
☐ Blames others for mistakes
☐ Deliberately annoys
☐ Often spiteful/vindictive
☐ Refuses to go to work
☐ Repeated nightmares
☐ Unusual fears
☐ Panic attacks
☐ Self-conscious/clings
☐ Self-injurious behavior
☐ Worry of future events
☐ Repeats certain actions
☐ Often bullies/threatens
☐ Initiates physical fights
☐ Ever been arrested
☐ Physically cruel to others
☐ Physically cruel to animals
☐ Motor or vocal tics
☐ Destroys property
☐ Deliberately sets fires
☐ Lies often
☐ Steals
☐ Has run away
☐ Extreme mood swings
☐ Does not show emotions
☐ Overreacts to touch/noise
☐ Strange or bizarre ideas
☐ Used drugs in the past
☐ Poor social interactions
☐ Often irritable
☐ Changes in appetite
☐ Diminished interest
☐ Sleep problems
☐ Often sad
☐ Excessive need for reassurance
☐ Difficulty maintaining friendships
☐ Somatic complaints (headache/stomach)
☐ Restlessness or slowed down
☐ Fatigues/low energy
☐ Feels worthless
☐ Becomes tearful easily
☐ Indecisive/can't think
☐ Thinks about death
☐ Talks about suicide
☐ Hurts self
☐ Gets upset by changes in routine
☐ Currently uses drugs
☐ Currently drinks beer or alcohol
☐ Used beer or alcohol in the past
☐ Can't stop thinking about things
☐ Excessive preoccupation with objects or idea

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Please place a check mark in the column which best describes you:	Not at all	Just a little	Pretty much	Very much
Often fails to give close attention to details or makes careless mistakes in work or other activities				
Often has difficulty sustaining attention in tasks or activities				
Often does not seem to listen when spoken to directly				
Often does not follow through on special instructions and fails to finish tasks, (not due to oppositional behavioral, but due to failure to understand directions)				
Often has difficulty organizing tasks and activities				
Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort				
Often loses things necessary for tasks or activities				
Is often easily distracted by extraneous stimuli				
Is often forgetful in daily activities				
Often fidgets with hands or feet or squirms in seat				
Often leaves seat in situations in which remaining seated is expected				
Often moves excessively in situations where it is inappropriate (may be limited to subjective feelings or restlessness)				
Often has difficulty playing or engaging in leisure activities quietly				
Is often "on the go" or often acts as if "driven by a motor"				
Often talks excessively				
Often blurts out answers before questions have been completed				
Often has difficulty waiting turn				
Often interrupts or intrudes on others (butts into conversation or activities)				

Childhood conditions had, please check:

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Whooping cough
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Rheumatic fever
- ☐ Typhoid fever
- ☐ Ear Infections
- ☐ Tubes in ears
- ☐ Chronic illness

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Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional **F** = Frequent **C** = Constant

O	F	C	**General**
			Allergy
			Chills
			Convulsions
			Dizziness
			Fainting
			Fevers
			Headaches
			Loss of sleep
			Nervousness
			Depression
			Neuralgia
			Numbness
			Sweats
			Loss of weight
			Tremors
O	**F**	**C**	**Muscle & Joint**
			Arthritis
			Bursitis
			Foot trouble
			Hernia
			Low back pain
			Neck pain
			Neck stiffness
			Pain between shoulders
O	**F**	**C**	**Respiratory**
			Chest pain
			Chronic cough
			Difficulty breathing
			Spitting blood
			Throat phlegm
			Wheezing
O	**F**	**C**	**Eyes, Ears, Nose & Throat**
			Colds
			Crossed eyes
			Deafness
			Dental decay
			Asthma
			Ear aches
			Ear discharge
			Ear noises

O	F	C	**Eyes, Ears, Nose & Throat**
			Tonsillitis
			Sinus infections
			Eye pain
			Failing vision
			Far sighted
			Gum trouble
			Hay fever
			Hoarseness
			Nasal obstruction
			Near sighted
			Nosebleeds
O	**F**	**C**	**Cardio-Vascular**
			Rapid heart beat
			Slow heart beat
			Swelling of ankles
			Hardening of arteries
			High blood pressure
			Pain over heart
			Poor circulation
O	**F**	**C**	**Gastro Intestinal**
			Excessive hunger
			Burping or gas
			Liver trouble
			Colitis
			Colon trouble
			Diarrhea
			Difficult digestion
			Distension of abdomen
			Stomach pain
			Gall bladder trouble
			Hemorrhoids
			Intestinal worms
			Jaundice
			Poor appetite
			Nausea
			Vomiting
			Vomit blood
O	**F**	**C**	**Skin**
			Boils
			Bruise easily

O	F	C	**Skin**
			Itching
			Skin rash
			Hives or allergy
			Dryness
			Varicose veins
O	**F**	**C**	**Genito-Urinary**
			Bed wetting
			Blood in urine
			Frequent urination
			Urinary incontinence
			Kidney infection
			Painful urination
			Prostate trouble
			Pus in urine
			Smell of urine
O	**F**	**C**	**Pain or Numbness in:**
			Shoulders
			Arms
			Hips
			Legs
			Knees
			Ankles
			Feet
			Painful tail bone
			Sciatica
			Swollen joints
O	**F**	**C**	**For Women Only**
			Cramps
			Heavy flow
			Light flow
			Irregular cycle
			Painful cycle
			Discharge
			Sore breasts

Menopausal: ☐ Yes ☐ No

Last Menstruation Date: ____________________

Pregnant: ☐ Yes ☐ No

Due Date: ____________________

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HABITS OF LIFESTYLE

Do you smoke? ☐ Yes ☐ No Do you exercise? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

Exercise Indoor Activities:

Exercise outdoor Activities:

Approximate sleep hours per night (check one): ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12+

Rate your sleep hours per night (check one): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Do you wake rested? ☐ Yes ☐ No

Rate your appetite: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Rate your diet: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Do you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner

Do you eat per day: ☐ 1 meal ☐ 2 meals ☐ 3 meals ☐ 4meals ☐ Over 4 meals

Do you take vitamins and minerals? ☐ Yes ☐ No
If yes, please list:

Do you take any recreational drugs? ☐ Yes ☐ No
If so, what?

Have you ever been knocked unconscious: ☐ Yes ☐ No ☐ Don't know
If so, for how long?

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REASON FOR ASSESSMENT

Please describe in your own words what concerns you have. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific question do you have that you hope an evaluation will answer?

Signature____ Date: ___________________

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