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Maple Grove, MN 55369
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Personal History - Adult

Today's Date: ____ /____ /____

Name: ________________________ What do you like to be called? ________________

Sex: M F (circle one) Age: ________ Birthdate: ____ /____ /____

Primary Care Physician / Clinic: ________________________________

Do you want us to contact this provider regarding your care here? ☐ Y ☐ N

What is the primary reason you are seeking services? ________________________

Your Past Medical History: (mark all that you have or had)

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Arrhythmia
- ☐ Atrial fibrillation
- ☐ Cancer / tumor
- ☐ Deep vein thrombosis
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart failure
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV / AIDS
- ☐ Liver problems
- ☐ Kidney problems
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Pancreatitis
- ☐ Parkinson's disease
- ☐ Pneumonia
- ☐ Rheumatoid arthritis
- ☐ Sinusitis
- ☐ Skin disease
- ☐ Sleep disorder (e.g., apnea, narcolepsy)
- ☐ Stroke / TIA
- ☐ Systemic lupus
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: ____________________

- When was your last physical exam? ______________
- *If female:* Are you currently pregnant? ☐ Yes ☐ No When was your last period? ______________

  Do your mental health symptoms worsen around your period? ☐ Yes ☐ N

Past Surgeries: (type of surgery and approximate year) ☐ None

1. ______________________________
2. ______________________________
3. ______________________________

Past Injuries: (type of injury and approximate date) ☐ None

1. ______________________________
2. ______________________________
3. ______________________________

- Have you ever been knocked unconscious? ☐ Yes ☐ No

  If yes, when and what happened? ________________________________

Current Medications:

Allergies: ________________________

Medication/Dose	Reason	Medication/Dose	Reason

- Who is prescribing your medications? ________________________________

Review of Physical Systems: (mark any of the following that frequently apply or are **currently** concern to you)

Head	Cardiovascular	Hematologic/Lymphatic
☐ dizziness/vertigo	☐ chest pain	☐ bleeding tendency
☐ blurred vision	☐ palpitations	☐ blood clots
☐ loss of vision	☐ irregular heart beat	☐ easily bruises
☐ loss of hearing	☐ swelling of feet	
☐ loss of smell	☐ heart murmur	Endocrine
☐ loss of taste		☐ heat intolerance
☐ eye pain	Respiratory	☐ cold intolerance
☐ ear pain	☐ shortness of breath	☐ excessive thirst
☐ ringing / buzzing	☐ wheezing	
☐ sinus drainage	☐ coughing	Skin
		☐ rash
Neurologic	Gastrointestinal	☐ hair loss
☐ headache	☐ nausea	☐ sores
☐ memory loss	☐ vomiting	☐ dryness/flaking
☐ difficulty concentrating	☐ stomach pain/heartburn	
☐ speech difficulty	☐ difficulty swallowing	General
☐ blackout / fainting	☐ blood in stool	☐ unexplained fevers
☐ seizures	☐ constipation	☐ weight loss
☐ trouble walking	☐ diarrhea	☐ weight gain
☐ falling	☐ loss of bowel control	☐ severe fatigue
☐ clumsiness		☐ difficulty with sleep
☐ weakness	Genitourinary	
☐ numbness / tingling	☐ frequent urination	**For Staff Use:**
☐ shaking / tremor	☐ painful urination	
☐ cramping / twitching	☐ loss of bladder control	______________________
	☐ sexual problems	______________________
Musculoskeletal	☐ irregular menstruation	______________________
☐ neck pain	☐ heavy menstruation	______________________
☐ back pain	☐ excessive cramping	
☐ joint pain		

Your Past Mental Health History: (mark all that you have or had)

- ☐ Anxiety
- ☐ ADHD
- ☐ Alcoholism
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating disorder: ______________________
- ☐ Drug addiction: ______________________
- ☐ Obsessive-compulsive disorder
- ☐ Panic attacks
- ☐ Phobia (extreme fear of something)
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Personality disorder: ________________
- ☐ Schizophrenia
- ☐ Social anxiety
- ☐ Other: ____________________________

- Have you done therapy in the past? ☐ Yes ☐ No

  If yes, when and with whom? ____

  Was it helpful? ☐ Yes ☐ No If no, why not? ____________________________________

- Have you ever taken medications for a mental health disorder? ☐ Yes ☐ No

  If yes, who prescribed them? ____

  Please list what you have taken: ____

- Have you ever been hospitalized for a mental health issue? ☐ Yes ☐ No

  If yes, how many times? ______ When/where was the last hospitalization? ________________

- Have you ever attempted suicide? ☐ Yes ☐ No

  If yes, how many times? ______ When was the last attempt? ________________________

- Have you ever engaged in self-injury (e.g., cutting, burning, etc.)? ☐ Yes ☐ No

  If yes, please describe? ____

- Are there any other mental health providers involved in your care? ☐ Yes, __________________ ☐ No

  If yes, do you want us to contact him/her regarding this assessment? ☐ Yes ☐ No

Family Health History: (mark if a blood relative has or had any of the following problems)

- ☐ Alzheimer's
- ☐ Anxiety
- ☐ ADHD
- ☐ Alcoholism
- ☐ Bipolar Disorder
- ☐ Brain tumor
- ☐ Brain aneurysm
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Epilepsy / seizures
- ☐ Migraines
- ☐ Heart disease
- ☐ Huntington's
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Parkinson's
- ☐ Schizophrenia
- ☐ Stroke
- ☐ Tics / Tourette's
- ☐ Tremor
- ☐ Other: ____________________
- ☐ Completed suicide

Immediate Family	**If Living**		**If Deceased**	
	Age Now	Current Health Status	Age at death	Cause of death
Mother		☐ good ☐ fair ☐ poor		
Father		☐ good ☐ fair ☐ poor		
Spouse / Partner ☐ male ☐ female		☐ good ☐ fair ☐ poor		
Siblings: (mark sex)				
☐ male ☐ female		☐ good ☐ fair ☐ poor		
☐ male ☐ female		☐ good ☐ fair ☐ poor		
☐ male ☐ female		☐ good ☐ fair ☐ poor		
☐ male ☐ female		☐ good ☐ fair ☐ poor		
Children: (mark sex)				
☐ male ☐ female		☐ good ☐ fair ☐ poor		
☐ male ☐ female		☐ good ☐ fair ☐ poor		
☐ male ☐ female		☐ good ☐ fair ☐ poor		
☐ male ☐ female		☐ good ☐ fair ☐ poor		

Social History:

Family of Origin:

Parents were: ☐ never married ☐ married ☐ separated ☐ divorced ☐ widowed

Parents remarried? ☐ Yes, ____ ☐ No

Special circumstances (e.g., raised by person(s) other than your parents):________________________

____

Education:

How many years of school have you completed? ____________ Area(s) of study ______________________

What was school like for you (e.g., grades, issues with peers/teachers)? ________________________

____

Work status:

☐ work FT ☐ work PT ☐ student ☐ unemployed ☐ temp. disabled ☐ perm. disabled ☐ retired

Occupation(s): ____

Have you ever been fired from a job? ☐ Yes ☐ No

If yes, please describe: ____

Do you have any current concerns about your job or work status? ☐ Yes ☐ No

If yes, please describe: ____

Military:

Military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No

Active duty dates: _____ / _____ / _____ to _____ /_____ /_____

In what way, if any, has your military experience affected your mental health? ______________________________

____

____

Legal:

Do you have a history of any misdemeanor or felony charges? ☐ Yes ☐ No

If yes, please describe: ____

Have you ever served time in jail or prison? ☐ Yes ☐ No

If yes, please describe: ____

Are you currently involved in any active cases (traffic, civil, criminal)? ☐ Yes ☐ No

If yes, please describe the nature of the case and any scheduled court, hearing or trial dates: ____________________

____

Are you currently on probation or parole? ☐ Yes ☐ No

If yes, please describe: ____________________________ Who is your P.O.? ______________________

Current Living Situation:

Marital status: ☐ single ☐ married ☐ partnered ☐ widowed ☐ separated ☐ divorced

Children? ☐ Yes, please list names and ages: ____ ☐ No

Step-children? ☐ Yes, please list names and ages: ____ ☐ No

Who do you live with?

Name	*Relationship*	*What concerns, if any, do you have regarding this relationship?*

Do you wish to involve any of your family, friends or other loved ones in your care? ☐ Yes ☐ No

If yes, who? ____

Review of Mental Health Symptoms: (mark any of the following that frequently apply or are **currently** concern to you)

Mood	Anxiety	Sleep	Attention
☐ sad/depressed mood ☐ decreased interest in usual activities/hobbies ☐ decreased libido ☐ excess guilt ☐ feelings of worthlessness ☐ low energy ☐ low motivation ☐ poor concentration ☐ indecisive ☐ change in appetite ☐ moving or talking slower than usual ☐ moving or talking faster than usual ☐ inflated self-esteem ☐ feeling elated or euphoric ☐ racing thoughts ☐ increased goal-directed behavior ☐ increased risk-taking behavior ☐ recurrent thoughts of death/suicidal ideation	☐ excess worry ☐ unable to control or stop worrying ☐ feeling wound-up, unable to relax ☐ restless, unable to sit still ☐ irritability ☐ muscle tension ☐ panic ☐ startle easily ☐ social ☐ phobias: ____________ ____________ ☐ obsessions: ____________ ____________ ☐ compulsions: ____________ ____________ Trauma Related Issues ☐ history of trauma ☐ flashbacks ☐ dissociation ☐ effort to avoid trauma-related stimuli	☐ difficulty falling asleep ☐ difficulty staying asleep ☐ sleeping too much ☐ not feeling rested in the morning ☐ decreased need or desire for sleep ☐ reversed sleep pattern (i.e., awake at night & asleep during the day) ☐ nightmares/night terrors How many hours of sleep do you average a night? _______ Do you snore? ☐ Yes ☐ No Have you ever done a sleep study? ☐ Yes ☐ No Eating Behaviors ☐ overeating ☐ withholding/starving ☐ binging ☐ purging ☐ fear of gaining weight ☐ excessive exercise ☐ use of laxatives	☐ poor attention to details ☐ easily distracted ☐ trouble finishing tasks ☐ trouble organizing activities ☐ procrastination ☐ often lose things ☐ forget activities (e.g., appointments, due dates) ☐ often fidgets ☐ difficulty staying seated ☐ feel driven by a motor ☐ often talk excessively ☐ blurt out answers or interrupt others Other ☐ anger outbursts ☐ abusive actions toward others: ____________ ☐ fears of abandonment ☐ self-injurious behavior ☐ hallucinations ☐ auditory ☐ visual ☐ paranoia: ____________ ☐ delusions: ____________

- Describe how the above symptoms affect your ability to function on a daily basis: ______________________________

  ____

  ____

  ____

- Is there any other information you think is important for me to know about you? ______________________________

  ____

  ____

  ____

- What are your goals for therapy? ____

  ____

  ____

  ____

Client Signature: ______________________________________ **Date:** _____ / _____ / ______