OAKLAND PSYCHOLOGICAL CLINIC, P.C.

# ADULT CONFIDENTIAL HISTORY

Name _____ Occupation _____

Date of Birth _____ Adopted □ Natural □ Where Were You Born? _____

Where Were You Raised? _____

## EDUCATION

Highest grade or degree completed _____ Year _____

Additional educational information _____

## FAMILY

**Spouse** (age, education, occupation, years married) _____

If married before, years of marriage, divorces, deaths _____

_____

| **Children:** | **Name** | **Age** | **Natural, Step or Adopted?** | **Lives with you?** Yes | No |
|---|---|---|---|---|---|
| | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ |

| **Other family members** | Living | Deceased | Lives with you? Yes | No | Age | Quality of Relationship |
|---|---|---|---|---|---|---|
| Mother | _____ | _____ | _____ | _____ | _____ | _____ |
| Father | _____ | _____ | _____ | _____ | _____ | _____ |
| Step-Mother | _____ | _____ | _____ | _____ | _____ | _____ |
| Step-Father | _____ | _____ | _____ | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |
| Grandparents | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |
| Other (specify) | _____ | _____ | _____ | _____ | _____ | _____ |

**INPUT OF PATIENT OR FAMILY**

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

_____

_____

What do you want the clinic to help you accomplish? _____

_____

_____

What are your goals for counseling or treatment?

Short Term _____

Long Term _____

Have any family members been treated for emotional or substance abuse problems? _____

_____

Family history of alcohol use, substance use or abuse. Include problem drinking and drug abuse, consequences of use, years used:

_____

_____

Average number of alcoholic drinks per week _____

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

_____

Any LGBTQ or gender identity concerns? ☐ No ☐ Yes, please explain:_____

_____

_____

_____

Please list previous mental health and/or substance abuse treatment:

Facility/Provider_____Date_____

Facility/Provider_____Date_____

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) _____

**MEDICAL**

Current Height _____ Current Weight _____

| | Yes | No |
|---|---|---|
| Do you feel excessively tired and/or weak? | _____ | _____ |
| Have you lost or gained weight for no apparent reason over the past six months? | _____ | _____ |
| Have you lost interest in eating lately? | _____ | _____ |
| Have you had a decrease in sexual interest lately? | _____ | _____ |
| Are you currently pregnant? | _____ | _____ |
| Are you currently breast-feeding? | _____ | _____ |
| Allergies/Sensitivities, if Yes, list below | _____ | _____ |

Medication Allergies: _____

Food Allergies: _____

Environmental Allergies: _____

Accidents or injuries (Include dates) _____

_____

Hospitalizations (Include hospital name and dates)_____

_____

Disabilities, Limitations or Ailments at this time _____

_____

Are you experiencing any physical pain? □ YES □ NO

Area of Pain _____

**Pain Rating Scale**: (circle one) |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe Very Severe Worst Possible Pain

Is this pain being addressed? □ Yes □ No If yes, how? _____

If no, why not? _____

Name and address of primary care physician: _____

_____

When were you last examined by a physician? _____

_____ _____

Patient Signature Date

_____ _____

Therapist Signature Date

This Confidential History Form constitutes a data-gathering document that is part of the patient's Comprehensive or Biopsychosocial Assessment.