ADULT SUPPLEMENTARY INFORMATION

To be completed by client's ages 18 years or older

Client's Full Name: ______________________________ Date of Birth: ____________ (MM/DD/YYYY)

MEDICAL HISTORY:

Please list any significant childhood illnesses:

Please list any surgeries and when they were performed:

Have you ever had a seizure, head trauma, or loss of consciousness? ☐ Yes ☐ No
If yes, please describe:

Have you ever had a CT scan, EEG, or MRI? ☐ Yes ☐ No
If yes, please describe:

Have you ever been hospitalized? ☐ Yes ☐ No
If yes, please describe:

Have you ever been seen in the emergency room? ☐ Yes ☐ No
If yes, please describe:

Per the Health Insurance Portability and Accountability Act (HIPAA) this information is strictly confidential.

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ADULT SUPPLEMENTARY INFORMATION
-CONTINUED-

If female, do you have regular menses? ☐ Yes ☐ No

Date of the most recent physical exam: ___________________________ (MM/DD/YYYY)

Is your vision within normal limits? ☐ Yes ☐ No

Is your hearing within normal limits? ☐ Yes ☐ No

Please list any medication and doses you are taking currently, including over-the-counter and herbal vitamins.

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-
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-
-
-

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list the medication and the reaction:

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ADULT SUPPLEMENTARY INFORMATION
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FAMILY HISTORY:

Please list any blood ***or*** *non-blood relative with the following: (Specify whether on maternal side or paternal side of the family)*

Substance abuse: ______________________________

Attention deficit: ______________________________

Learning problems or mental retardation: ______________________________

Depression: ______________________________

Bipolar disorder (manic-depression): ______________________________

Schizophrenia: ______________________________

Autism: ______________________________

Obsessions/Compulsions: ______________________________

Panic: ______________________________

Eating disorders: ______________________________

Other Anxiety: ______________________________

Suicide: ______________________________

Diabetes: ______________________________

Cancer (specify type): ______________________________

Hypertension or heart disease: ______________________________

Thyroid disease: ______________________________

Liver disease: ______________________________

Kidney disease: ______________________________

Migraines: ______________________________

Tics: ______________________________

Genetic syndromes (please specify): ______________________________

Neurologic disorders (Parkinson’s, multiple sclerosis, Alzheimer’s, etc.): ______________________________

____

Epilepsy: ______________________________

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ADULT SUPPLEMENTARY INFORMATION
-CONTINUED-

SOCIAL HISTORY:

Please list name and ages of all persons living in your home:

-
-
-
-
-
-

How do you do socially?

Recreational activities:

Any legal issues:

Do you use recreational drugs or alcohol? ☐ Yes ☐ No
If yes, please estimate frequency and quantity of use:

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ADULT SUPPLEMENTARY INFORMATION
-CONTINUED-

PREVIOUS TREATMENT:

Is this your first mental health consultation? ☐ Yes ☐ No
If no, please list the following where applicable:

Previous evaluations (evaluator, date of evaluation, recommendations):

Previous psychotherapy (therapist, dates of treatment):

Previous medication trials (name of medications, dose, how long the medication was taken):
Note: If uncertain, this information may be obtained from your pharmacy where prescriptions were filled.

Previous psychiatric hospitalizations (hospital name, dates of hospitalization, treatment received during the hospitalization):

PLEASE CHECK ANY SYMPTOMS BELOW THAT YOU ARE CURRENTLY HAVING:

___ weight changes
___ fever
___ headaches
___ changes in vision or hearing
___ chest pain or heart palpitations
___ dizziness
___ fainting
___ trouble breathing
___ stomach discomfort
___ nausea or vomiting

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ADULT SUPPLEMENTARY INFORMATION
-CONTINUED-

___ diarrhea
___ constipation
___ problems with urination
___ irregular menstrual cycles (if applicable)
___ muscle or joint pain
___ numbness or weakness
___ hair loss
___ easy bleeding or bruising

Please contact previous provider to request any pertinent medical records and have them faxed to your 3-C Family Services' clinician prior to your first appointment so they may be reviewed prior to your consultation.
3-C Family Services fax # **(919) 677.0113**

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