LINCOLN FAMILY MEDICAL GROUP, P.C.
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Adult History Form

1. Biographical Information

First Name: MI: Last Name: Date of Birth:

Preferred method(s) and days or times for your counselor to contact you:

☐ Phone ☐ Email

Days/Times:

2. Counseling Concerns

Please describe the concerns for which you are seeking counseling and when the issues began:

What goals do you hope to accomplish as a result of our working together?

3. Family History

Parent/Guardian:

Occupation: Highest level of education completed:

Medical and Psychiatric history:

Parent/Guardian:

Occupation: Highest level of education completed:

Medical and Psychiatric history:

Briefly describe the atmoshpere and relationshsips you experienced in childhood.

Any additional information you would like us to know about home or your family, including psychiatric history of extended family members:

4. Developmental and Social History

Were you adopted?
○ Yes ○ No

Did you meet developmental milestones on time?
○ Yes ○ No ○ Unknown

Any developmental milestones not met on time:

Where did you grow up?

Describe any spiritual or religious affiliation or preferences:

Current relationship status:
○ Single ○ Relationship ○ Married ○ Divorced ○ Widowed

Please provide the names and ages of any children:

Please provide a list of people you currently live with:

5. Medical History

Current or past medical issues:

Allergies:

Name of Primary Care Doctor:

Date of your last check up with primary care doctor:

Current medications, including dosages, prescriber of the medication, and any over-the-counter medicines or supplements:

Any injuries or accidents, particularly blows to the head (car accidents, bike falls, etc)?

Have you ever been hospitalized for medical treatment or surgery?
○ Yes ○ No

If Yes, at what age and for what reason(s)?

Any difficulties with getting to or staying asleep?
○ Yes ○ No

Estimated hours of sleep per night:

Estimated hours spent on screens per day:

If applicable, date of last menstrual cycle:

6. Psychiatric History

Have you participated in therapy before?
○ Yes ○ No

If yes, when, what was the reason, and with whom?

Please list any previous medications you have been prescribed for your mental health and any reasons why you went off those medications:

Have you been hospitalized for psychiatric reasons?
○ Yes ○ No

If yes, when, what was the reason, and where?

Have you ever, or are you currently experiencing suicidal thoughts or feelings?
○ Yes ○ No

If yes, please describe:

Have any of your family members died from suicide?
○ Yes ○ No

Have you ever, or are you currently experiencing homicidal thought or feelings?
○ Yes ○ No

If yes, please descibe:

Have you ever engaged in self-harm?
○ Yes ○ No

If yes, please describe:

7. Alcohol and Substance Use

Have you ever felt like you have an issue of misusing alcohol or substances?

○ Yes ○ No

If yes, please describe:

Have any of your family members ever had an issue of misusing, or participated in treatment for, alcohol or substance use?

○ Yes ○ No

If yes, please describe:

8. Educational and Occupational Information

Highest level of education completed:

Current employment:

Have you ever served in the military:

○ Yes ○ No

Do you have any current concerns related to education or employment:

○ Yes ○ No

If yes, please describe:

9. Trauma History

Do you have a history of trauma, abuse, or neglect?

○ Yes ○ No

If yes, please provide any details you feel comfortable sharing at this time. Please note your counselor may follow up with additional questions as you feel comfortable.

10. Legal History

Do you have any past or pending legal issues?

11. Strengths and Interests

What are your strengths, abilities, and/or current special interests?

Who are your support systems (family, friends, mentors, etc.)?

What do you find currently helpful for any of your concerns? What strengths do you have that will be helpful in the counseling process?

12. **Additional Comments or issues not addressed in the preceding sections**

13. **Current Symptoms Checklist - Below is a list of frequently reported problems and concerns. Please indicate the extent to which any of these problems has affected you during the past two weeks by scoring each item according to its degree of severity (0=none, 1=mild, 2=moderate, 3=severe).**

	Score
Feeling down, depressed, or blue	
Feeling lonely	
Low motivation to get things done	
Issues with eating	
Difficulty making decisions	
Trouble concentrating	
Restlessness or excessive energy	
Fatigue	
Worry	
Trouble falling asleep	
Awaking during the night with problems returning to sleep	
Awaking 1-2 hours before rising and remaining awake	
Tension in shoulders, neck or chest	
Stomach discomfort	
Spells of panic	
Rapid, shallow breathing	
Thoughts of ending your life	
Troubled by Internet usage	
Irritability	

Temper outbursts you cannot control	
Feeling guilty	
Feeling hopeless	
Feeling worthless	
Loss of interest in things, people or activities	
Thinking you are superior to other people	
Feeling you are watched or talked about by others	
Seeing or hearing things of which others are unaware	
The idea that something is wrong with your mind	
Sexual concerns	
Body discomfort	