Psychotherapy Associates of Tampa Bay L.L.C

ADULT PATIENT HISTORY FORM

DEMOGRAPHIC INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Gender: □ Male □ Female □ Transgender

Marital Status: □ Never Married □ Domestic Partners □ Married □ Separated □ Divorce □ Widowed

Social Security #: _____ Driver's License #/State: _____

Education: □ G.E.D. □ High School Diploma □ Some College □ Associate's □ Bachelor's □ Graduate Degree

Occupation (if applicable): _____

Religious Affiliation (if applicable): _____

Current reason(s) for seeking treatment:

_____

_____

_____

_____

FAMILY INFORMATION:

	Name	Occupation	Education	Religion	Age	Deceased?
1.	Spouse:					
2.	Mother:					
3.	Father:					
4.	Siblings:					

_____

_____

_____

_____

If applicable, please list any children you have and their ages:

1. _____
2. _____
3. _____
4. _____

Names of other persons living in the household and relationship to you (if applicable):

_____

MEDICAL & MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good Excellent

2. Please list any specific health problems you are currently experiencing:

_____

_____

_____

3. Primary Care Physician's Name and Location:

_____

4. Date and reason for most recent physical exam:

_____

_____

5. Current Prescription Medications:

Name	Date Started	Dosage	Frequency	Purpose
1.				
2.				
3.				
4.				
5.				

6. Current Over-the-Counter Medications/Vitamins/Supplements:

1. _____
2. _____
3. _____

7. Allergies: _____

8. Current Medical Conditions/Treatments:

1. _____
2. _____
3. _____
4. _____
5. _____

9. Previous Surgeries and Dates:

1. _____
2. _____
3. _____

10. Previous Hospitalizations and Dates:

1. _____
2. _____
3. _____

11. Previous Medical Illnesses/Injuries, Treatments and Dates:

1. _____
2. _____
3. _____
4. _____
5. _____

12. Have you received any type of mental health treatment in the past (i.e., psychotherapy, psychiatric services, etc.)? □ No □ Yes

13. If yes, please specify the nature of the treatment provided as well as the name and location of previous therapist/practitioner:

_____

_____

_____

14. Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and provide dosage and dates:

_____

15. Have you ever been hospitalized on an inpatient basis for psychiatric purposes? □ Yes □ No

If yes, please provide dates and circumstances:

_____

_____

_____

_____

16. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good Excellent

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

17. How many times per week do you exercise? _____ Type(s) of exercise:

_____

_____

18. Please list any difficulties you experience with your appetite or eating patterns and note recent weight loss/gain.

_____

_____

_____

19. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, please explain symptoms and duration:

_____

20. Are you currently experiencing anxiety, panic attacks, or have any fears? □ No □ Yes
If yes, please explain symptoms and duration:

_____

21. Are you currently experiencing any chronic physical pain? □ No □ Yes
If yes, please describe.

_____

_____

22. How often do you consume alcoholic beverages? Drink(s) of choice: _____

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

23. How often do you engage in recreational drug use? Type(s): _____

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

24. Are you currently in a romantic relationship? □ No □ Yes

If yes, for approximately how long? _____

25. On a scale of 1-10 (10 being optimal), how would you rate your current level of relationship satisfaction and why?

_____

_____

_____

26. What significant life changes or stressful events have you experienced in the past? Recently?

_____

_____

_____

27. Family's Mental Health History:

In the section below, please identify if you have a family member who has any of the following. If yes, please indicate his or her relationship to you in the space provided (e.g., mother, father, grandmother, sibling, etc.)

Alcohol/Substance Abuse	□ No	□ Yes	_____
Anxiety	□ No	□ Yes	_____
Depression	□ No	□ Yes	_____
Domestic Violence	□ No	□ Yes	_____
Eating Disorders	□ No	□ Yes	_____
Obsessive/Compulsive	□ No	□ Yes	_____
Schizophrenia/Psychosis	□ No	□ Yes	_____
Suicide Attempts	□ No	□ Yes	_____
Personality Disorders	□ No	□ Yes	_____

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

_____

2. Do you enjoy your work? Is there anything stressful about your job?

_____

_____

3. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, please describe your faith or belief:

_____

_____

4. What do you consider to be some of your strengths?

_____

_____

_____

5. What do you consider to be some of your limitations?

_____

_____

_____

6. Please describe how you see yourself:

_____

_____

_____

7. Please describe how you believe others see you:

_____

_____

_____

8. What would you like to accomplish out of your time in therapy?

_____

_____

_____

9. Please provide any comments or concerns that you may have or any additional information you would like your treatment provider to know about you:

_____

_____

_____

_____