THE LAKEWOOD GROUP, LLC
Mental Health Services

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CONFIDENTIAL ADULT HISTORY

PATIENT INFORMATION: Date ____-____-____

Name _____ Birthdate ____-____-____ Place of birth _____

Age _____, Gender_____, Race (Optional) _____, Religion (Optional) _____

Years in school _____ Highest degree obtained (if any) _____

Occupation _____ Employer_____

Family Physician _____ Please list any other physicians who have treated you in the past 2 years _____

FAMILY INFORMATION:
Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced. Living with a spouse or mate? ☐ Yes ☐ No

Name_____ Relationship _____

Age _____ Occupation _____ Employer _____

Address_____ Work phone _____

Check all that apply to your relationship: ☐ Very Satisfactory ☐ Satisfactory ☐ Tolerable ☐ Intolerable.
☐ Minor problems & conflicts ☐ Major and continuing problems & conflicts.

Reasons for relationship problems: Check all that apply: ☐ finances ☐ children ☐ parents or in-laws
☐ work situation ☐ personality differences ☐ religion ☐ sexual difficulties ☐ physical illness ☐ legal
☐ communication problems ☐ child discipline ☐ other_____

Date of 1st Marriage_____ ☐ Separated ☐ Divorced ☐ Widowed Date_____ Name_____

Children (Names,sex,ages)_____

Date of 2nd Marriage_____ ☐ Separated ☐ Divorced ☐ Widowed Date_____ Name_____

Children (Names,sex,ages,his/hers)_____

Date of 3rd Marriage_____ ☐ Separated ☐ Divorced ☐ Widowed Date_____ Name_____

Children (Names,sex,ages,his/hers)_____

Describe any additional marriages or children_____

Number of people living in your household _____ Please list names and relationships _____

_____

_____

CURRENT PROBLEMS:
What concerns led you to seek treatment?_____

_____

How long have these problems existed?_____ What has been tried to solve the problems? _____

_____

Have you had previous evaluations or treatment by a psychologist, psychiatrist or counselor? □ Yes □ No, If yes:

Dates	Location	Therapist	Results

Has any medication been prescribed for these problems? □ Yes □ No If yes:

Medication	Strength	Number taken	Physician Prescribing	Results
		□ /day □ /wk		
		□ /day □ /wk		
		□ /day □ /wk		
		□ /day □ /wk		

What do you think might be causing the problem?_____

_____

MEDICAL HISTORY:

Are you or have you ever been under the care of a physician for any type of medical problem other than the reason for being here? If so, please explain:

Dates	Location	Physician	Problem and Treatment

Please list all **medications** you are currently taking:

Medication	For what	Strengt h	Number taken	Physician Prescribing	Results
			□ /day □ /wk		
			□ /day □ /wk		
			□ /day □ /wk		
			□ /day □ /wk		

Non-prescription medications _____

Please list all medications you are allergic to, including X-ray dye _____

_____

Please list any and all **surgeries**:

Dates	Location	Physician	Problem and Treatment

Please list any **other hospitalizations**:

Dates	Location	Physician	Problem and Treatment

Approximate date of your last checkup ____-____-____ Done for: □ Illness □ Routine □ Work □ Insurance

Results_____

Name of Physician _____ Address _____ Phone_____

Included in checkup: □ Physical □ Blood tests □ Urine tests □ X-ray □ EKG (cardiogram) □ Pap smear

Date of your last tetanus shot ____-____-____

Height _____ Weight _____ Weight one year ago _____ 10 lb. weight change in past year? □ Yes □ No

Number of cigarettes + cigars + pipefuls + dips _____ □ /day □ /wk. □ /mo. □ /yr. Age began using _____

Number of alcoholic drinks _____ □ /day □ /wk. □ /mo. □ /yr. Age began using _____ Last drunk _____

Have you ever used alcohol more heavily than you do now? □ Yes □ No Have you ever taken unprescribed

drugs including "street" drugs? □ Yes □ No, If yes, please specify _____

_____

Number of caffeine drinks per day: _____ coffee _____ tea _____ colas _____Mountain Dew _____other

FOR WOMEN: (If you are uncomfortable answering any of these questions, you may respond later in private.)
Are you having periods? □ Yes □ No Date of last normal menstrual period ____-____-____ Age puberty onset____

Menses: □ Normal □ Heavy □ Irregular, Please Explain _____

_____ Possibility of current pregnancy? □ Yes □ No

Number of: Pregnancies _____ Miscarriages _____ Complications _____ Abortions _____

History of venereal diseases (herpes, gonorrhea, syphilis, etc.):_____

Date of last Pap smear ____-____-____ Birth Control Pills _____

Recent change in sexual functioning:_____

FOR MEN: (If you are uncomfortable answering any of these questions, you may respond later in private.)

Age puberty onset _____ Any problems with sexual performance _____

History of venereal disease (herpes, gonorrhea, syphilis, non-specific discharge, etc.):_____

_____

Recent change in sexual functioning:_____

FOR MEN AND WOMEN: Please indicate if you have experienced any of the following:

CONDITION	YES	AGES	CONDITION	YES	AGES	CONDITION	YES	AGES
Fever in last week			Periods of unconscious			Bladder difficulty		
Frequent headaches			Seizures or convulsions			Bowel difficulty		
Recent change in hearing			Vision problems			Miscarriage		
Recent change in vision			Frequent ear trouble			Tumors		
Numbness			Hearing impairment			Pneumonia		
Muscular weakness			Female disease/disorder			Baker's cyst		
Dizziness			Heart disease			Kidney disease		
Seizures			Asthma			Rheumatic fever		
Tics			Allergies			Soft tissue inflammation		
Trouble breathing			Speech difficulty			Lymphangitis		
Chronic cough			Diabetes			Scabies		
Coughed up blood			Vasectomy			Serious accident		
Chest pains			Cancer			Surgery		
High Blood Pressure			Tuberculosis			Paralysis		
Abdominal pains			Memory difficulty			Shaking		
Change in bowel habits			Hypoglycemia			Ulcer		
Rectal bleeding			Scarlet fever			Insomnia		
Difficulty or pain in urination			Bursitis			Nervousness		
Blood in urine			Phlebitis			Depression		
Blackouts			Herpes Witlow			Alcohol use		
Trouble with walking or balance			Shortness of breath			Drug use		
Back Pain			Frequent diarrhea or constipation			P.M.S.		
Other back problems			Frequent nausea or vomiting			Sexual dysfunction		
Arthritis			High blood pressure			Sterility		
Frequent ear infections			Low blood pressure			Hysterectomy		
Frequent sore throats			Meningitis			Menstrual difficulty		
Severe headaches			Liver disease			Thyroid difficulty		
Head injury			Weight loss			Balance difficulty		
Fainting spells			Weight gain			Dropping objects		
Episodes of prolonged or high (>103) fever								

If any of the above were answered yes, please describe further._____

_____

_____

Family Medical History:	Age	Medical or Psychological Problems	Age Died	Year Died	Cause of Death
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Father					
Mother					
Brothers 1)					
2)					
3)					
4)					
Sisters 1)					
2)					
3)					
4)					
Children 1)					
2)					
3)					
4)					

Check if anyone in your family has had: □ Diabetes □ Alcohol problems □ Drug problems □ Weight problems □ Depression □ Anxiety □ Other psychological problems □ Heart or blood pressure problems □ Headaches