



# THE LAKEWOOD GROUP, LLC

*Mental Health Services*

2237 Ridge Road • Suite 101 • Rockwall, Texas 75087-5161  
(972) 771-3969 • Fax: (972) 771-8258  
www.lakewoodgroup.net

**Robert F. Mehl, III, Ph.D. & Associates, LLC**  
Robert F. Mehl, III, Ph.D.  
H. Michael Cunningham, Ph.D.  
Christine M. Gonzalez, Ph.D., LSSP  
Johnathan L. Fowler, Ph.D.  
Michael K. Johnson, Ph.D.  
Joni L. Caldwell, Ph.D.  
Karlene Gacita, Psy.D.  
Kristen E. Wilson, Ph.D.  
Mary Watts Crutchfield, M.D., P.A.

## 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
		<input type="checkbox"/> /day <input type="checkbox"/> /wk		
		<input type="checkbox"/> /day <input type="checkbox"/> /wk		
		<input type="checkbox"/> /day <input type="checkbox"/> /wk		
		<input type="checkbox"/> /day <input type="checkbox"/> /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	Strength	Number taken	Physician Prescribing	Results
			<input type="checkbox"/> /day <input type="checkbox"/> /wk		
			<input type="checkbox"/> /day <input type="checkbox"/> /wk		
			<input type="checkbox"/> /day <input type="checkbox"/> /wk		
			<input type="checkbox"/> /day <input type="checkbox"/> /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