DR. VICTORIA FITZGERALD, PLLC

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Adult History Form

Identification

Name: _____DOB:_____Todays: Date:_____

Address:_____

Contact Phone:_____Contact Email and/or 2nd Phone:_____

Occupation:_____ Place of employment:_____

Relationship Status: Dating/Single/Married?Divorced:_____

Any children?____ If so, ages:_____

Referred by:_____

The following confidential information will be used to provide us with a more complete understanding of you. If you have any doubts about your answer, respond to the best of your ability and place a question mark (?) at the end. If you are unable to answer the question, please leave it blank. Thank you for your asistance.

Referral Situation

1. What recent events or concerns have led to your seeking an evaluation?

2. Please state in your own words the nature of your present concerns? Please list any symptoms that are bothering you:

3. Were your concerns first noted by someone else?_____ If so, by whom?

4. Please describe briefly your goals and expectations for yourself and what you hope may be accomplished through an evaluation:

Personal and Social History

(a) Date of Birth:_____ Place of Birth:_____

(b) Siblings: Number of Brothers:_____ Brothers' Ages:_____

Number of Sisters:_____ Sisters' Ages:_____

(c) Father(s): Living?_____ If alive, give father's present age:_____

If deceased, give his age at time of death:_____

Cause of death:_____

Father's occupation:_____

(d) Mother(s): Living?_____ If alive, give mother's present age:_____

If deceased, give her age at time of her death:_____

Cause of death:_____

Mother's occupation:_____

(e) Religion/spirituality: As a child:_____As an adult:_____

(f) Education: What is the last grade completed (degree)?:_____

(g) Any particular issues of concern that applied during your childhood/adolescence? Learing/Educational/Social Please describe.

(h) What do you do for a living?

(i) Does your present work satisfy you?_____ If not, please explain

(j) Have you ever been hospitalized for psychological problems?_____ If yes, when and where:

(k) Do you have a family physician? _____ If so, please give his/her name(s) and telephone number(s)

When was your last medical exam?

(l) Have you ever attempted suicide?_____ Injured yourself on purpose? _____

Physical Health Factors

Do you have any current concerns about your physical health? Please specify:_____

_____

Please list any medicines you are currently taking, or have taken during the past 6 months (including aspirin, birth control pills, or any medicines that ere prescribed or taken over the counter)_____

_____

_____

Do you eat three well-balanced meals each day? If not, please explain:_____

_____

Do you get regular physical exercise? If so, what type and how often?_____

_____

Please check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens (LSD, etc)				

Have you ever had any head injuries or loss of consciousness? Please give details:

Please describe any surgery you have had (give dates):

If you wish to add any additional comments/information to this form, please feel free to do so in the space below. Your patience and thoroughness in completing this form will be of great benefit in this assessment. Thank you for your cooperation.