

Adult – Confidential Health History



Full Name:	DOB:	Today's Date:
Street Address:	City/State:	Zip:

SSN: _____ Phone: _____ Email: _____ Age: _____ First Language: ___English ___Spanish ___Other: _____ English Fluent? ___Yes ___No Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____ Ethnicity: <input type="checkbox"/> Not Hispanic/Not Latino <input type="checkbox"/> Other Hispanic, Latino of Central/South America <input type="checkbox"/> Latino unknown origin <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban Marital Status: ___Married ___Single ___Separated ___Divorced ___Widowed Dependent Children: ___Yes ___No Are you in need of behavioral health services? ___Yes ___No Do you receive medical care, including immunizations? ___Yes ___No Family Financial Support: ___ Food Stamps ___ TANF Employed? ___Yes ___No In need of employment support? ___Yes ___No Education Level: ___Some High School ___Diploma/GED ___Some College ___College ___Other: _____	Biological Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (Female-to-Male) <input type="checkbox"/> Transgender Female (Male-to-Female) <input type="checkbox"/> Gender non-conforming <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other: _____ Sexual Orientation: <input type="checkbox"/> Lesbian, gay, homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other: _____ Impairments/Disabilities: <input type="checkbox"/> Learning or Reading Disability <input type="checkbox"/> Communication Difficulties <input type="checkbox"/> Developmental Disabilities <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Other: _____	Are you court-ordered, out of jail, or on probation? <input type="radio"/> Yes <input type="radio"/> No Do you have a probation officer? <input type="radio"/> Yes <input type="radio"/> No PO Name: _____ #: _____ Court: _____ Judge: _____ Tobacco/Smoking Habits: <input type="checkbox"/> Never <input type="checkbox"/> Light everyday <input type="checkbox"/> Everyday <input type="checkbox"/> Heavy everyday <input type="checkbox"/> Smokeless Tobacco (Vape, Chew, E-Cigs) <input type="checkbox"/> Former smoker Home Status: <input type="checkbox"/> Permanent Housing <input type="checkbox"/> Temporarily living with others <input type="checkbox"/> Homeless <input type="checkbox"/> Public shelter <input type="checkbox"/> Institutional Housing <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Other: _____ <i>How long have you lived in your current housing situation?</i> <input type="checkbox"/> Less than 6 months <input type="checkbox"/> 6 months -1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2+ years Military Veteran? ___Yes ___No Immediate family member in military? ___Yes ___No
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What support needs do you have today?

Please list any mental health/addictions services you've received:

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Members in Household Name:	Relationship:	Age:	Occupation:

Over the past 2 weeks, how often have you experienced the following?	None	Some Days	Most Days	Everyday
Little interest/pleasure in doing things				
Feeling down/depressed/hopeless				
Trouble sleeping too little or too much				
Feeling tired/not having enough energy				
Poor appetite or overeating				
Feeling bad about yourself				
Trouble concentrating				
Moving/speaking slower, or being fidgety/restless				
Wanting to be dead				
Wanting to hurt others				
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

Substance Use History: NA: <input type="radio"/>	Route Taken:	How Obtained:	How Much:	How Often:	Age of First Use:	Last Use:
<input type="radio"/> Alcohol						
<input type="radio"/> Marijuana						
<input type="radio"/> Methamphetamine						
<input type="radio"/> Crack/Cocaine						
<input type="radio"/> Opiates/Heroin						
<input type="radio"/> Benzodiazepines						
<input type="radio"/> Other:						

Have you ever had difficulty with alcohol or other drugs?	<input type="radio"/> Yes	<input type="radio"/> No
Does anyone in your family currently have difficulty with alcohol or other drugs?	<input type="radio"/> Yes	<input type="radio"/> No
Have you ever used drugs using an IV needle?	<input type="radio"/> Yes	<input type="radio"/> No

History of Substance Use Problems (past 12 months; check any that apply):			
<input type="radio"/> Failed attempts to stop use	<input type="radio"/> Guilt due to excessive use	<input type="radio"/> Criticism by others	<input type="radio"/> Physical injury
<input type="radio"/> Memory blackouts	<input type="radio"/> Perceptual Disturbance	<input type="radio"/> Legal Problems	<input type="radio"/> Missed work
<input type="radio"/> Arguments or fights	<input type="radio"/> loss of consciousness	<input type="radio"/> Hallucinations	<input type="radio"/> Incarceration
<input type="radio"/> Medical problems	<input type="radio"/> Shared needle use	<input type="radio"/> Tremors	<input type="radio"/> Seizures
<input type="radio"/> Problems with family/friends	<input type="radio"/> Problems with home responsibilities	<input type="radio"/> Financial problems	

If in recovery, longest period (number of days) of sobriety in past six months: _____

Have you attended AA/NA 12 Step programs before? Yes No Number of Meetings Attended in the last 30 days: _____

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Eating Disorder				
Headaches / Migraines				
Heart Disease/Hypertension				
History of Suicide Attempts				
Kidney Disease				
Learning Disability				
Liver Disease/Cirrhosis				
Lung Disease				
Pain Disorder				
Schizophrenia				
Seizures/Epilepsy				
Sleep Disorder				
Vision Problems				

Personal Treatment History

Treatment Provider	Type of Care	Dates of Care	Comments

Health Habits

Sexual Activity
 Sexually Active: Yes No Birth Control Method: _____
 Have you had sex with: Men Women Both

Exercise
 3x per week active 1-2x per week sedentary (very little to no regular activity)
 Activities engaged in: _____ Barriers to activity: _____

ABUSE/TRAUMA HISTORY NA

Current Abuse: NA Physical Emotional Exploitation Sexual Neglect
 Past Abuse: NA Physical Emotional Exploitation Sexual Neglect

While you were growing up, did a parent or other adult in the household often ...

Swear at you, insult you, put you down, or humiliate you? Yes No
 Act in a way that made you afraid that you might be physically hurt? Yes No

Push, grab, slap, or throw something at you? Yes No
 Ever hit you so hard that you had marks or were injured? Yes No

Did an adult or person at least 5 years older than you ever...

Touch or fondle you or have you touch their body in a sexual way? Yes No
 Try to or actually have oral, anal, or vaginal sex with you? Yes No

Did you often feel that...

No one in your family loved you or thought you were important or special? Yes No
 Your family didn't look out for each other, feel close to each other, or support each other? Yes No
 You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Yes No
 Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes No

Were your parents ever separated or divorced? Yes No

Was your mother/father or stepmother/stepfather: Yes No
 Often pushed, grabbed, slapped, or had something thrown at her?
 Or sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
 Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Yes No

Was a household member depressed or mentally ill or did a household member attempt suicide? Yes No

Did a household member go to prison? Yes No