Name: _____ Date: _____

KRIST SAMARITAN COUNSELING CENTER
Adult Clinical History Form

STRESSORS

Given the list of categories below, how much stress is each currently causing you?

	None	Mild Stress	Moderate Stress	Severe Stress
Family				
Friends				
Relationships				
Educational				
Economic				
Occupational				
Housing				
Legal				
Health				

SUBSTANCE ABUSE HISTORY

	Yes	No
Do you have a history of any recreational drug use?		

If YES, please fill out the table below to the best of your knowledge.

Substance(s) used	Yes	No	Age at first use	Age at last use	How was it taken?	Amount per day	Days per month
Amphetamines/speed					__ Oral __ Nasal __ Inhaled __ Injected		
Barbiturates/downers					__ Oral __ Nasal __ Inhaled __ Injected		
Opiates					__ Oral __ Nasal __ Inhaled __ Injected		
Cocaine					__ Oral __ Nasal __ Inhaled __ Injected		

Substance(s) used	Yes	No	Age at first use	Age at last use	How was it taken?	Amount per day	Days per month
Psychedelics (e.g., LSD, Ecstasy, bath salts)					__ Oral __ Nasal __ Inhaled __ Injected		
Inhalants (e.g., glue, aerosols)					__ Oral __ Nasal __ Inhaled __ Injected		
Cannabis/Marijuana/Hashish					__ Oral __ Nasal __ Inhaled __ Injected		
Benzodiazepines					__ Oral __ Nasal __ Inhaled __ Injected		
PCP					__ Oral __ Nasal __ Inhaled __ Injected		
Synthetic Marijuana					__ Oral __ Nasal __ Inhaled __ Injected		
Alcohol					__ Oral __ Nasal __ Inhaled __ Injected		
Other:					__ Oral __ Nasal __ Inhaled __ Injected		
Other:					__ Oral __ Nasal __ Inhaled __ Injected		

	Yes	No
Did you receive any treatment for substance abuse?		

If YES, please fill out the table below to the best of your knowledge.

Treatment Type	Yes	No	How many episodes of treatment?	Age of first treatment	Age of last treatment	Any additional treatment information?
Inpatient/Residential						
Partial Hospitalization (PHP)						
Intensive Outpatient (IOP)						
Outpatient						
12-Step Program						
Other:						
Other:						

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances? (Please check all that apply.)

	Yes	No
No consequences		
Felt that you needed to cut down on your drinking/use		
Been annoyed by others criticizing your drinking/use		
Felt guilty about drinking/use		
Need a drink/to use first thing in the morning		
Increased tolerance		
Withdrawal (e.g., shakes, sweating, nausea, rapid heart rate)		
Seizures		
Blackouts		
Effects on physical health		
Using/consuming more than intended		
Unintentional overdose		
DUI		
Arrests		
Physical fights or assaults		
Relationship conflicts		
Problems with money		
Job loss or problems at work/school		
Other:		
Other:		

PSYCHIATRIC HISTORY

	Yes	No
Do you have a history of inpatient psychiatric treatment?		

If YES, please list any inpatient psychiatric treatment history below.
Start with the most recent and list each episode of treatment as a separate line.

Hospital/Facility	Treatment voluntary?	Primary reason for hospitalization	How old were you?	Treatment outcome	Additional comments
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				
	Yes No				

	Yes	No
Do you have a history of outpatient psychiatric treatment?		

If YES, please list any outpatient treatment history below.
Start with the most recent and list each episode of treatment as a separate line.

Treatment Provider	Primary reason for seeking treatment	Age of first treatment	Age of last treatment	Treatment outcome	Additional comments

	Yes	No
Have you ever tried to harm or kill yourself?		
Was your intent to die?		

Elaborate, if desired: _____

_____

_____

How many times in your life has this occurred? _____

Please describe your most *severe* episode:

Month: _____ Year: _____

Method: _____ Consequence: _____

Please describe your most *recent* episode:

Month: _____ Year: _____

Method: _____ Consequence: _____

	Yes	No
Have you had any history of violent behavior?		

If YES, please elaborate: _____

_____

_____

MEDICAL HISTORY

Who is your primary care physician? _____

	Yes	No
Are you taking any medications currently? (excluding psychiatric medications)		

If YES, please list the medications here: _____

_____

_____

Have you a history of any of the following health problems? (Please check all that apply.)

	Yes	No		Yes	No
No problems			Hemorrhoids		
			Hepatitis		
Allergies			Hernia		
Anemia (low blood count)			HIV		
Arthritis			Hypertension (high blood pressure)		
Asthma			Hyperthyroidism		
Back Problems (including disc or spine)			Hypotension (low blood pressure)		
Cancer			Hypothyroidism		
Cataracts			Inflammatory Bowel Disease		
Chickenpox (as a child)			Iron deficiency		
Chronic Bronchitis			Kidney disease		
COPD (Emphysema)			Kidney stones		
Diabetes			Liver disease		
Diverticulitis			Lupus		
Fainting spells/passing out			Migraine headaches		
High cholesterol			Multiple Sclerosis		
Fibromyalgia			Obesity/overweight		
Gall Bladder disease			Parkinson's disease		
Gastritis or Ulcer			Polyps		
Glaucoma			Seizures		
Gout			Sleep apnea		
Hearing loss			Stroke/TIA		
Heart disease			Testosterone (low)		
Heart defect from birth			Tuberculosis (or exposure to TB)		
Heart valve problems			Other:		

Have you a history of surgery in any of the following areas? (Please check all that apply.)

	Yes	No		Yes	No
No surgical history			Liver		
			Lung		
Back/Neck			Pancreas		
Brain			Pelvis		
Cardiac			Penis		
Ear/Nose/Throat			Prostate		
Gall Bladder			Sex Change		
Hernia			Shoulder/Elbow/Wrist/Hand		
Hip/Knee/Ankle/Foot			Stomach		
Hysterectomy (ovaries removed)			Tonsils		
Hysterectomy (ovaries retained)			Vagina		
Intestine			Weight Loss		
Kidney			Other:		

PSYCHIATRIC MEDICATION HISTORY

	Yes	No
Have you ever taken any medication for psychiatric treatment?		

If YES, please fill out the table below to the best of your knowledge.

Medication Name	Dose	How long? (months)	End date	Therapeutic effect	Side effects	Reason for stopping

	Yes	No
Do you have any known allergies to medication?		

If YES, please fill out your allergy information below.

Medication Allergy	Allergic Reaction

FAMILY HISTORY

	Yes	No
Do you have any family members with a history of psychiatric illness?		

If YES, please elaborate below.

Condition	Family Member(s)	Maternal or Paternal?
ADHD		M P
Alcoholism		M P
Anxiety		M P
Autism/PDD/Asperger's Syndrome		M P
Bipolar Disorder		M P
Criminal Record		M P
Delayed Language		M P
Depression		M P
Drug Addiction		M P
Dyslexia		M P
Eating Disorder (indicate type)		M P
Explosive Temper		M P
Mental Retardation/IDD		M P
Obsessive Compulsive Disorder (OCD)		M P
Other Learning Disability (indicate type)		M P
Personality Disorder (indicate type)		M P
Psychiatric Hospitalization		M P
Schizophrenia		M P
Siezures/Epilepsy		M P
Suicide (completed or attempted)		M P
Trauma/PTSD		M P
Other:		M P
Other:		M P
Other:		M P

	Yes	No
Is there any additional family medical history?		

If YES, please elaborate: _____

_____

_____

SOCIAL HISTORY: DEVELOPMENTAL AND EDUCATIONAL

During your pregnancy/birth, did your mother have problems with any of the following?

	Yes	No
None of these		
Exposure to drugs or alcohol during pregnancy		
A difficult pregnancy. If so, how:		
Problems with delivery. If so, how:		
Other:		

Did you have any complications after your birth?

	Yes	No
None of these		
Prematurity		
Jaundice		
Heart complications		
Breathing difficulties		
Cord wrapped around neck		
Swallowed meconium		
Forceps used		
Stayed in NICU. If so, how long:		
Other:		

Did you have any delays or difficulties in reaching the following developmental milestones?

	Yes	No
None of these		
Walking		
Talking		
Toilet training		
Sleeping alone		
Being away from parents		
Making friends		
Other:		

Which options below best describe your childhood atmosphere?

	Yes	No
Normal		
Supportive		
Parental fighting		
Parental violence		
Financial difficulties		
Frequent moving		
Other:		
Other:		

Which of the following challenges were experienced during your childhood?

	Yes	No		Yes	No
None of these			Fighting		
			Stealing		
Tantrums			Property damage		
Enuresis (bed wetting)			Fire setting		
Encopresis (incontinence)			Animal cruelty		
Running away from home			Separation anxiety		

Which of the following best describe problems you may have had in school?

	Yes	No		Yes	No
None of these			Expulsions		
			School refusal		
Fighting			Class failures		
School phobia			Repetition of grade(s)		
Truancy			Special education		
Detentions			Remedial classes		
Suspensions			Other:		

Did you have any additional schooling outside of the standard setting? (Please check all that apply.)

	Yes	No		Yes	No
None of these			Accommodations		
			Homeschool		
Speech			Other:		
Tutoring			Other:		

What is your highest level of education? _____

If you have any comments about your developmental and/or educational history and wish to elaborate further, please do so in the space provided: _____

_____

_____

SOCIAL HISTORY: GENERAL

Which options below best describe your social situation?

	Yes	No		Yes	No
Supportive social network			Distant from family of origin		
Few friends			Family conflict		
Substance-use based friends			Other:		
No friends					

What is your current marital status? _____

What is the status of your intimate relationship? _____

What is the satisfaction level of your intimate relationship? _____

What is your sexual orientation? _____

What is your current living situation? _____

Who do you currently live with? (Please check all that apply.)

	Yes	No		Yes	No
Alone			Partner/Spouse		
Roommates			Children		
Parent(s)			Other:		

	Yes	No
Do you currently participate in spiritual activities?		

What is your occupation status? _____

What is your current yearly income? _____

What is your longest period of continuous employment?
Start date: _____ End date: _____ Description: _____

What is your longest period of continuous unemployment?
Start date: _____ End date: _____ Description: _____

SOCIAL HISTORY: MENSTRUATION AND PREGNANCY

N/A (circle if not applicable)

At what age did you begin menstruation? _____

Which of these best describe your premenstrual symptoms? (Please check all that apply.)

	Yes	No		Yes	No
None of these			Appetite change		
			Bloating		
Dysphoria			Sleep disturbance		
Cramps			Other:		
Moodiness			Other:		

Have you ever been pregnant? _____ If YES, how many times? _____

Have you ever given birth? _____ If YES, how many times? _____

Have you had any miscarriages? _____ If YES, how many times? _____

Have you had any abortions? _____ If YES, how many times? _____

REVIEW OF SYSTEMS

Please look at the list of physical symptoms below and circle any that you have experienced in the last several days. If you have NOT experienced any symptoms in an area, be sure to circle "None of the above" for that area.

Constitutional		
Chronic pain	Loss of appetite	Increase in appetite
Unexplained weight loss	Weight gain	Fatigue/lethargy
Unexplained fever	Hot or cold spells	Night sweats
Sleeping pattern disruption	Malaise (flu-like/vague sick feeling)	
Other:	None of the above	
Eyes		
Eye pain	Eye discharge	Eye redness
Blurred or double vision	History of eye surgery	Sensitivity to light
Scotomas (blind spots)	Retinal hemorrhage (floaters)	Amaurosis fugax (filling like a curtain is pulled over vision)
Other:	None of the above	
Ears, Nose, Throat, and Mouth		
Earache	Tinnitus (ringing in ears)	Decrease hearing or hearing loss
Frequent ear infections	Frequent nose bleeds	Sinus congestion
Runny nose/post-nasal drip	Difficulty swallowing	Frequent sore throat
Prolonged hoarseness	Pain in jaw or tooth	Dry mouth
Other:	None of the above	
Cardiovascular		
Chest pain	Pacemaker	Swollen feet or hands
Palpitations (fast or irregular heartbeat)	Fainting spells	Shortness of breath with exercise
Other:	None of the above	
Respiratory		
Pain with breathing	Chronic cough	Chronic shortness of breath
Chronic wheezing/Asthma	Excessive phlegm	Cough blood
Nocturnal Dyspnea (shortness of breath at night)	Other:	None of the above
Musculoskeletal		
Swelling in joints	Redness of joints	Other joint pains or stiffness
Muscle pain or cramping	Muscle weakness	Muscle stiffness
Decreased range of motion	Back pain or stiffness	History of fractures
Past injury to spine or joints	Other:	None of the above
Gastrointestinal		
Excessive flatulence or belching	Heartburn	Change in appearance of stool
Diarrhea	Difficulty swallowing solids/liquids	Blood in stool
Constipation	Recent loss in appetite	Dark/tarry stool
Persistent nausea/vomiting	Sensitivity to milk products	Loss of bowel control
Abdominal pain	Jaundice (yellow skin)	
Other:	None of the above	
Allergic/Immunologic		
Frequent infections	Hives	Anaphylaxic reaction
Other:	None of the above	

Endocrine		
Severe menopausal symptoms	Cold or heat intolerance	Excessive appetite
Excessive thirst or urination	Excessive sweating	Diabetes
Other:	None of the above	
Hematologic/Lymphatic		
Blood clots	Easy bleeding after surgery or dental work	History of blood transfusion
Excessive bruising or bleeding		Swollen glands (neck, armpits, groin)
Other:	None of the above	
Genitourinary (general)		
Loss of urine control	Painful/burning urination	Blood in urine
Increased frequency of urination	Up more than twice a night to urinate	Urine retention
Frequent urine infection		
Other:	None of the above	
Genitourinary (women)		
Unusual vaginal discharge	Vaginal pain, bleeding, soreness, or dryness	Genital sores
Heavy or irregular periods		No menses (period stopped)
Currently pregnant	Sterility/Infertility	Any other sexual or sex organ concerns
Other:	None of the above	
Genitourinary (men)		
Slow urine stream	Scrotal pain	Lump or mass in the testicles
Abnormal penis discharge	Trouble getting/maintaining erections	Any other sexual or sex organ concerns
Inability to ejaculate/orgasm		
Other:	None of the above	
Neurological		
Paralysis	Fainting spells or blackouts	Dizziness/Vertigo
Drowsiness	Slurred speech	Speech problems (other)
Short term memory trouble	Memory difficulties (loss)	Frequent headaches
Muscle weakness	Numbness/tingling sensations	Neuropathy (numbness in feet)
Tremor in hands/shaking	Muscle spasms or tremors	
Other:	None of the above	
Integumentary (Skin, Breast, and Hair)		
Lesions	Unusual mole	Easy bruising
Increased perspiration	Rashes	Chronic dry skin
Itchy skin or scalp	Hair or nail changes	Hair loss
Breast tenderness	Breast discharge	Breast lump or mass
Other:	None of the above	
Psychiatric		
In-depth review of psychiatric system appears earlier in document	Feeling depressed	Difficulty concentrating
	Phobias/unexplained fears	No pleasure from life anymore
	Anxiety	Insomnia
Excessive moodiness	Stress	Disturbing thoughts
Manic episodes	Confusion	Memory loss
Other:	None of the above	