THE CENTER FOR INTERNET AND TECHNOLOGY ADDICTION

PLUG BACK INTO LIFE!℠

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ADULT PATIENT HISTORY

Patient: ______________________________ Date: ________________

Please list all of the people living in your household:

Name	Sex	Age	Place of work or school

List any family members not living with you. (For example, grown children, former spouse):

____

____

What problem(s) are you experiencing at this time? ____

____

____

What made you decide to see a therapist now? ____

____

____

Describe any current medical problems, including known drug allergies, or any past major illnesses, injuries, or surgeries: ____

____

____

Please list the names of the medications you take, including birth control pills and vitamins.

____

Check the appropriate box describing your use of cigarettes, alcohol, and marijuana

	CIGARETTES		**ALCOHOL**		**MARIJUANA**
Don't Smoke		Don't drink		Don't smoke	
Less than 1 pack/day		Drink 1/month		Smoke 1/month	
One pack/day		Drink 1/week		Smoke 1/week	
More than 1 pack/day		Drink more than 1/week		Smoke more than 1/week	
Do you want to quit?		Do you want to quit?		Do you want to quit?	

Have you ever been arrested for DWI/PUI?___________

If so, please indicate the number of DWIs and dates

____

____

Do you use other drugs (for example, cocaine, speed, etc.)? ___________
If yes, please describe:

____

____

Do you have any sleep trouble? ___________

If yes, check those areas that are problems:

Falling asleep___ Restless sleep____ Waking throughout the night____ Other(explain)

____

____

Have your eating habits or weight changed in recent months? ___________

If yes, check those areas that describe the change:

Weight loss____ Lost appetite____ Weight gain____ Increased appetite____

Have you ever seen a counselor or doctor for emotional, mental health, or substance abuse difficulties? ______
If yes, please list who and when:

____

____

Have you ever taken any medication for emotional, mental health, or substance abuse difficulties? ___________

If yes, what and when?:

____

____

Have you ever been in a hospital for emotional, mental health, or substance abuse difficulties?_______________

If yes, for what and when?

____

____

Have you ever deliberately hurt yourself, overdosed, or attempted suicide? __________

If yes, how many times, when, and how?

____

____

____

Have you had any feelings of wanting to hurt yourself or anyone else **over the past month**? ____________

If yes, please describe:

____

____

Do any of your family members have emotional, behavioral, mental health, or substance abuse difficulties?____

If yes, who and what? ____

____

____

What are your personal strengths and support system that have allowed you to cope with other difficult life situations in the past?

____

____

____

____

____

What other things would be helpful for your therapist to know to work most effectively with you?

____

____

____

____

What <u>specific</u> changes do you want to make in order to feel that your therapy experience has been successful?

1.____

2.____

3.____

4.____

Office use:

Check if the following information from the Client questionnaire was reviewed:

√	**Elaborate if remarkable (e.g., include information not already presented in the Client History questionnaire)**
	Family Hx of psychiatric problems:
	Prior mental health or substance abuse Tx:
	Current medications:

Review the following as needed:

√	**Elaborate if remarkable (e.g., include information not already presented in the Client History questionnaire)**
	Educational Hx:
	Vocational Hx:
	Military Hx:
	Other: