Adult Health History

Behavioral Sleep Medicine

Today's date: ______________________________

Patient Name: ______________________________ **Date of Birth:** ______________ **Age:** ________

Person completing this form: ____________________ **Relationship to patient:** ____________________

Gender: ☐ Female ☐ Male ☐ Other **Who referred you?** ______________________________

Ethnicity: ☐ Asian ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Other ______________________

Marital Status: (circle one)
married
separated
divorced
widowed
partnered
never married

Education: (circle highest level)
completed grade: 1 2 3 4 5 6 7 8 9 10 11 12 GED
years of college: 1 2 3 4
graduate degree: Master's Doctoral ________________

Children? ☐ Yes ☐ No **If yes, how many?** ______________

How happy are you with how you read in English? ☐ Very happy ☐ Ok ☐ Not very happy

What problem(s) are you seeking help for? ____

____

When did these problems start? ____

Why are you seeking help now? ____

____

Do you know what services are you interested in? ☐ Yes ☐ No

Counseling or psychotherapy: ☐ Yes ☐ No

Behavioral Sleep Medicine: ☐ Yes ☐ No

Do you have any of these medical problems?

Heart Disease	☐ Yes	☐ No	Neurological Disorder	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	COPD/asthma	☐ Yes	☐ No
Chronic Pain	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Recent injury	☐ Yes	☐ No

Do you have any other medical problems? ____

____

Are you allergic to anything? ____

Who is your primary care doctor? ____

Do you see any specialist doctors? ____

FOR WOMEN ONLY: Have you had any problems with menstruation, pregnancy or childbirth? ☐ Yes ☐ No

If yes, describe: ____

Did you ever have a concussion or head injury? ☐ Yes ☐ No If yes, describe: ________________

____

Were you ever diagnosed with a psychiatric disorder? ☐ Yes ☐ No

If yes, which one(s)? ______________________________

If yes, how long ago? ______________________________

Have you ever been in counseling before? ☐ Yes ☐ No

When was it? ______________________________

Who did you see? ______________________________

Did it help? How? ______________________________

Have you ever seen a psychiatrist? ☐ Yes ☐ No If yes, for what? ______________________________

____

Have you ever had personality testing, IQ testing, or neuropsychological testing? ☐ Yes ☐ No

If yes, please describe: ______________________________

Did you have any learning problems in school? ☐ Yes ☐ No If yes, describe: ______________________________

____

Have you had any losses or traumas in your life? ☐ Yes ☐ No If yes, describe: ______________________________

____

Have you ever been in a psychiatric hospital? ☐ Yes ☐ No If yes, describe: ______________________________

____

Have any of your family members been diagnosed or treated for a psychiatric problem?

Family Member	Type of Psychiatric Problem

Where were you born and raised? ______________________________

Who raised you? ______________________________

Were there any drug or alcohol problems in your childhood home? ______________________________

If yes, describe: ______________________________

Was there violence in your childhood home? ☐ Yes ☐ No If yes, describe: ______________________________

____

Was there any abuse towards you? ☐ None ☐ Physical ☐ Sexual ☐ Verbal ☐ Emotional

Were you ever in the military? ☐ Yes ☐ No When? ______________________________

Who do you live with now? ______________________________

____

How stressful are your finances? ______________________________

____

Were you ever convicted of a crime? ☐ Yes ☐ No If yes, please describe: ____________________

____

Have you had any other legal problems? (example: bankruptcy, being sued, etc) ☐ Yes ☐ No

If yes, describe: ____________________

Are you part of a religious/spiritual group? ☐ Yes ☐ No Which one? ____________________

Are you: employed / unemployed / disabled / retired **What job do you have?** (if any) ____________________

What jobs did you have in the past? ____________________

What do you do for enjoyment or fun? ____________________

____

Symptoms (please check "yes" or "no")**:**

1. In the last few weeks have you felt little enjoyment in doing things? ☐ Yes ☐ No
2. In the last few weeks have you felt down, depressed, or hopeless? ☐ Yes ☐ No
3. In the last few weeks have you felt nervous, anxious, or on edge? ☐ Yes ☐ No
4. In the last few weeks has it been difficult to control your worries? ☐ Yes ☐ No
5. In the last few weeks did you have an anxiety attack – suddenly feeling panic? ☐ Yes ☐ No
6. Have you ever had a problem with drinking too much alcohol? ☐ Yes ☐ No
7. Have you ever used drugs - now or in the past? ☐ Yes ☐ No
8. Have you been hooked on prescription medication? ☐ Yes ☐ No
9. Have you been thinking or dreaming about something terrible from the past? ☐ Yes ☐ No
10. Have you been hit, slapped, kicked, or physically hurt by someone, or has someone forced you to have an unwanted sexual act? ☐ Yes ☐ No
11. Have you been thinking about hurting yourself or someone else? ☐ Yes ☐ No
12. Do you have problems with your memory or concentration? ☐ Yes ☐ No
13. Do you have problems with planning or making decisions? ☐ Yes ☐ No
14. Do you have difficulty with your spouse or family? ☐ Yes ☐ No

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Is there anything else you want Dr. Reitav to know? ____________________

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Thank you for completing this overview of your health status.

Reviewed by:

Health specialist: ____________________ Date: ____________________