1820 Center Ave. Ste. 170 • Janesville, Wisconsin 53546
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ADULT AND FAMILY HEALTH AND HISTORY

Client Name: ______________________________ D.O.B: _____________ Age: ________ Date______________

Gender Identity: ___________________________________ Race/Ethnicity: _______________________________

Medical Condition and History

Primary Physician/Clinic: ___________________________________ Last Physical: ____________________

Current illnesses/injuries/conditions? ☐ Yes ☐ No ____

Describe significant past illnesses, surgeries, hospitalizations for medical conditions (include appox. dates):

____

____

____

Any problems with physical pain? ☐ Yes ☐ No How severe? _____ (1 – 10)

Any recent unplanned weight loss or gain? ☐ Yes # of pounds ____ ☐ No

Are you currently or have you ever been treated for the following:

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		Allergies			Gastro-Intestinal Problem			Sickle Cell Disease
		Asthma			Heart Disease			Sleep Disorders
		Bleeding Disorder			Kidney Disease			Stroke
		Blood Pressure			Learning Disorder			Surgery
		COPD			Menstrual Problem			Thyroid Disease
		Diabetes			Musculo-Skeletal Problem			Serious Injury
		Ear / Sinus Problem			Psychological / Psychiatric			Other:
		Fainting			Seizures			Other:

Please explain yes answer (as needed): ____

____

Medication(s) you are currently taking, please include over-the-counter drugs, herbal supplements and vitamins

Medication	Dosage	Reason you are taking medication	Prescriber

Medication Allergies – please include medication and corresponding allergic reaction (i.e. hives, rash, fever…)

Relevant Family Composition & History

* **0** = No Contact;1 = Poor; 2 = Somewhat satisfactory; 3 = Good; 4 = Excellent

	Name/Age	Living? Yes/No	Living with you? Yes/No	History of mental health, substance abuse or health concerns? (Please Describe)	Relationship Quality* (See above)
Father		☐ yes ☐ no	☐ yes ☐ no		0 1 2 3 4
Mother		☐ yes ☐ no	☐ yes ☐ no		0 1 2 3 4
Step-parents		☐ yes ☐ no	☐ yes ☐ no		0 1 2 3 4
Others significantly involved in raising you		☐ yes ☐ no	☐ yes ☐ no		0 1 2 3 4
Sister/Brother		☐ yes ☐ no	☐ yes ☐ no		0 1 2 3 4
Sister/Brother		☐ yes ☐ no	☐ yes ☐ no		0 1 2 3 4
Sister/Brother		☐ yes ☐ no	☐ yes ☐ no		0 1 2 3 4
Sister/Brother		☐ yes ☐ no	☐ yes ☐ no		0 1 2 3 4

Additional health information you may consider relevant:

____

____

____

____

Childhood Experiences

☐ Yes ☐ No Are you adopted?

☐ Yes ☐ No Were you in foster care?

☐ Yes ☐ No Are you aware of any complications during your mother’s pregnancy and during your birth?

☐ Yes ☐ No Premature birth

☐ Yes ☐ No Mother’s substance use during pregnancy

☐ Yes ☐ No Mother experienced trauma or abuse during pregnancy

☐ Yes ☐ No Mother’s health issues during pregnancy

☐ Yes ☐ No Did you meet developmental milestones (e.g., walking, talking, potty training) at the appropriate ages?

☐ Yes ☐ No Do you remember your needs being met as a child (e.g., for love, food, shelter)?