

# Lindsey Kremmel, PhD

91 West Neal Street • Pleasanton, CA 94566 • Phone: 510-982-6477 • Web: www.DrLindseyKremmel.com

## Adult History Form

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Nickname (if any): \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Sexual Orientation:  Heterosexual  Gay/Lesbian  Bisexual  Other: \_\_\_\_\_

Relationship Status:  Married  Divorced  Single  Widowed  
 Unmarried Long-Term Relationship

Race/Ethnicity:  Caucasian  African American/Black  Asian Indian  
 Asian  Native American  Hispanic/Latino/a  
 Native Hawaiian/Pacific Islander  Other: \_\_\_\_\_

Education Level:  Grade School  High School  College  
 Professional/Trade School  Graduate School

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

### **Contact Information:**

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Therapist may leave a detailed message at:  Home  Work  Cell

### **Living Situation:** List all of the people who currently live with you

Name	Relationship	Age	Occupation/School Grade

### **Emergency contact person:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Referred by** (How did you hear about my practice?): \_\_\_\_\_

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Main problem/major reason for seeking help at this time and how long you've been having this problem:

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Describe any other problems you are currently having:

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Describe the impact of these problems in your life (relationships, work, etc):

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What have you already tried to resolve these problems?

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Briefly describe *past* and *current* psychological treatment including psychotherapy, medication, testing:

<b>Dates</b>	<b>Facility/Therapist/Doctor</b>	<b>Reason for Treatment</b>	<b>Helpful? (Yes/No)</b>

- Have you had inpatient (stayed in the hospital) mental health treatment?       Yes    No
- Have you *ever* attempted suicide?       Yes    No
- Are you *currently* having thoughts or planning to harm yourself/suicide?       Yes    No
- Are you *currently* having thoughts or planning to seriously harm someone else?       Yes    No
- Do you have a history of abuse (physical, sexual, emotional, neglect)?       Yes    No
- Is anyone *currently* hitting, insulting, threatening, or slapping you?       Yes    No
- Is there legal action affecting you?       Yes    No

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Are you currently taking any medications? { } Yes { } No If yes, include the following information:

Name of Medication	Dosage	Prescribed by	Date Started

Are you currently under the care of a physician for any serious medical conditions? { } Yes { } No

If yes: Doctor's Name: \_\_\_\_\_ Treatment for: \_\_\_\_\_

Indicate if any family members or relatives have the following problems:

Problem:	Family member (mom, dad, sister, uncle, etc):
Depression	
Bipolar Disorder (Manic-Depressive)	
Nervous disorders/Anxiety	
Alcohol/Drug Problems	
Learning disabilities/delays	
Problems with attention or hyperactivity (ADHD)	
Autism/Asperger's	
Other Mental Health Problem: _____	
Serious illness: _____	
Other problems: _____	

What are your support systems? (church, friends, clubs etc.) \_\_\_\_\_

What are your strengths? \_\_\_\_\_

Additional information you want me to know:

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