



ADULT SUPPLEMENTARY INFORMATION

To be completed by client's ages 18 years or older

Client's Full Name: _____

Date of Birth: _____
(MM/DD/YYYY)

MEDICAL HISTORY:

Please list any significant childhood illnesses:

Please list any surgeries and when they were performed:

Have you ever had a seizure, head trauma, or loss of consciousness? Yes No
If yes, please describe:

Have you ever had a CT scan, EEG, or MRI? Yes No
If yes, please describe:

Have you ever been hospitalized? Yes No
If yes, please describe:

Have you ever been seen in the emergency room? Yes No
If yes, please describe:



**ADULT SUPPLEMENTARY INFORMATION
-CONTINUED-**

If female, do you have regular menses? Yes No

Date of the most recent physical exam: _____ (MM/DD/YYYY)

Is your vision within normal limits? Yes No

Is your hearing within normal limits? Yes No

Please list any medication and doses you are taking currently, including over-the-counter and herbal vitamins.

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Are you allergic to any medications? Yes No

If yes, please list the medication and the reaction:



**ADULT SUPPLEMENTARY INFORMATION
-CONTINUED-**

FAMILY HISTORY:

Please list any blood or non-blood relative with the following: (Specify whether on maternal side or paternal side of the family)

Substance abuse: _____

Attention deficit: _____

Learning problems or mental retardation: _____

Depression: _____

Bipolar disorder (manic-depression): _____

Schizophrenia: _____

Autism: _____

Obsessions/Compulsions: _____

Panic: _____

Eating disorders: _____

Other Anxiety: _____

Suicide: _____

Diabetes: _____

Cancer (specify type): _____

Hypertension or heart disease: _____

Thyroid disease: _____

Liver disease: _____

Kidney disease: _____

Migraines: _____

Tics: _____

Genetic syndromes (please specify): _____

Neurologic disorders (Parkinson's, multiple sclerosis, Alzheimer's, etc.): _____

Epilepsy: _____



**ADULT SUPPLEMENTARY INFORMATION
-CONTINUED-**

SOCIAL HISTORY:

Please list name and ages of all persons living in your home:

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How do you do socially?

Recreational activities:

Any legal issues:

Do you use recreational drugs or alcohol? Yes No

If yes, please estimate frequency and quantity of use:



**ADULT SUPPLEMENTARY INFORMATION
-CONTINUED-**

PREVIOUS TREATMENT:

Is this your first mental health consultation? Yes No

If no, please list the following where applicable:

Previous evaluations (evaluator, date of evaluation, recommendations):

Previous psychotherapy (therapist, dates of treatment):

Previous medication trials (name of medications, dose, how long the medication was taken):

Note: If uncertain, this information may be obtained from your pharmacy where prescriptions were filled.

Previous psychiatric hospitalizations (hospital name, dates of hospitalization, treatment received during the hospitalization):

Please contact previous provider to request any pertinent medical records and have them faxed to your 3-C Family Services' clinician prior to your first appointment so they may be reviewed prior to your consultation.

3-C Family Services fax # (919) 677.0113