WILLIAM G. DEUBERT, PSY.D.
LICENSED CLINICAL PSYCHOLOGIST

1489 CHAIN BRIDGE ROAD, SUITE 203
MCLEAN, VA 22101
703.268.8556
VIRGINIA LICENSE NO. 0810002990
WM G DEUBERT, LLC EIN 26-2949901

ADULT HISTORY FORM

Patient Name: _____ Date of birth: _____

Date form completed: _____ Gender: M F (circle one)

Reason for seeking treatment: _____

How long has this problem existed? 1-3 months 6 -12 months 1-2 years 2-5 years 5+ years

Prior therapy: Yes No Name of clinician: _____

If yes: What was the duration? Brief Long-term

In what environment? Outpatient Periodic sessions Day Treatment Inpatient

Was it: Helpful Not Helpful Not Sure

What can I do to help you? _____

_____

_____

_____

_____

Current primary physician: _____

Whom can I thank for referring you? _____

Current marital status: _____

Previous marriages? Yes No

Have you ever been divorced? Yes No

If yes, how long did the marriage(s) last? _____

Please explain: _____

_____

Occupation: _____

Current employment: _____

High School graduate: Yes No GED College graduate: Yes No

If Yes: Degree(s) or number of credits: _____

Field of study: _____

Occupational training (please explain): _____

_____

Military service: _____

Religious affiliation: _____

Recreation (list some usual activities): _____

_____

_____

_____

_____

_____

List all of those with whom you reside, and designate the relationship(s) and age(s):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have children who do not live with you? Yes No

If yes, please provide the name(s) and age(s):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have there been deaths in your family or among your friends? Yes No

If yes, who: _____ When: _____

_____ _____

_____ _____

Have you moved recently? No Yes

If yes, when? _____

Have you moved often? No Yes If yes, please explain: _____

_____

_____

Do you plan to move in the near future? No Yes

If yes, please explain: _____

_____

_____

Work History for the Past 10 Years

Employer	Job Title	Date Started	Date Left	Reason For Leaving
1.				
2.				
3.				
4.				
5.				

Your Family of Origin

Please provide data on your mother, father, siblings, and any step or half-family members:

Name and relationship	Age	Health Status	Occupation	Where Resides	Frequency of Contact
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Have you ever been separated from family members for a prolonged period? No Yes

Were there any separations from your family or either parent when you were a child (e.g., mother hospitalized)? No Yes

If yes, please explain: _____

Is there any history (diagnosed or undiagnosed) of mental, emotional, or psychiatric problems in your family (e.g., anxiety, OCD, depression, ADHD, mood disorders, bipolar disorder, schizophrenia, substance abuse, or neurological problems)?

No Yes

If yes, please explain: _____

Health History

List any medications taken:

On a Regular Basis Now	Previously

Hospitalizations:

Date	Medical or Psychiatric	Reason	Which Hospital

Please provide a history of each pregnancy, miscarriages, or abortion: _____

Please list any chronic health conditions (e.g., asthma, high blood pressure): _____

Please list any serious accidents for which you did not require hospitalization: _____

What is your current general state of health? _____

Symptoms and Behaviors Checklist

Please answer every question, even if the response is "no." Indicate the severity of the symptom, if known, for the past year.

SYMPTOM	SEVERITY			
	NO	MILD	MODERATE	SEVERE
Depression				
Tearfulness				
Feeling Lonely				
Feeling Sad				
Withdrawn				
Spending more time alone				
Moody				
Avoiding friends				
Concerned about injury/bodily harm				
Eating more				
Eating less				
Weight change				
More exercise				
Less exercise				
Decreased interest in sex				
Decreased interest in usual activities				
Tired				
Sleeping more				
Sleeping less				
Waking during the night				
Waking early in the morning				
Sleepwalking				
Nightmares/bad dreams				
Headaches				
Careless about dress/hygiene				
Having trouble concentrating				
Confused				
Distractible				
Impulsive				
Disorganized				
Hearing things others don't hear				
Seeing things others don't see				
Trouble following directions				
Perfectionistic/Overly Rigid				

SYMPTOM	SEVERITY			
	NO	MILD	MODERATE	SEVERE
Anxious				
Worrying				
Feeling panicky				
Obsessive/ritualistic behaviors				
Critical of others				
Have few friends				
Low self-esteem				
Disappointed in appearance				
Disappointed in achievements				
Disappointed in social life				
Legal problems/ever been arrested				
Problems at work				
Trouble controlling aggression				
Arguing				
Defiant				
Destroying/damaging property				
Irritable				
Angry				
Easily frustrated				
Giving away belongings				
Threats to oneself				
Wishes to be dead				
Suicidal thoughts				
Suicidal intent				
History of self-injurious behavior				
Homicidal thoughts				