

PATIENT HISTORY FORM

INSTRUCTIONS TO PATIENT/FAMILY Please complete this form. It will provide us with important information about you and your needs. **Please do not write in Staff Section.**

Patient Name _____ Date _____

Current Living Situation Complete the following table regarding your immediate family:

FAMILY MEMBER	AGE	RELATIONSHIP TO PATIENT	LIVING WITH PATIENT?	EDUCATION LEVEL	OCCUPATION	INVOLVEMENT WITH PATIENT

FAMILY/OTHER IMPORTANT RELATIONSHIPS Please note marital status, past marriages, divorces, dating and relationships. Describe degree of support received from family, friends, school, support groups and others.

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FAMILY OF ORIGIN Please describe your relationships with parents/caregivers and brothers/sisters. Note any family problems that were present, such as history of drug abuse or mental illness in family members.

EDUCATION Provide level of schooling completed, feelings about school, and grades. Please note any discipline problems or learning difficulties. Also, please indicate how you prefer to learn (for example: reading, practicing, talking or watching).

EMPLOYMENT Provide work history, retirement, terminations, problems on the job, EAP involvement, relationships with co-workers and bosses, shifts, hours per week.

Not Applicable

MILITARY Yes No Not Applicable

Active Yes No

Combat Yes No

Branch _____

Length _____

Type of Discharge _____

Disciplinary Action _____

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LEGAL HISTORY Note any legal difficulties including arrests, nature of charges, convictions, pending charges, guardianship, power of attorney. If you have a probation/parole officer, please provide name and phone number.

RELIGION/SPIRITUALITY Please describe past and present religious affiliations, involvement in church and guiding spiritual principals.

Are there any spiritual/religious issues you would like help addressing?

What spiritual/religious resources do you make use of? (Circle all that apply)

Prayer Faith Community Spiritual Friend Spiritual Reading
Church Attendance Other _____

CULTURAL Please describe your ethnic background, community and customs. Include any cultural issues you would like help addressing.

Please list any cultural issues/practices you would like us to be aware of that would affect your treatment.

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VIOLENCE/ABUSE Please describe any physical, verbal, emotional or sexual abuse as the perpetrator, victim or witness. Was the abuse reported to the authorities?

FINANCIAL STATUS Please describe past and present credit history, include any if you are receiving disability or public assistance.

Financially secure
Plan to file

Finances are a source of stress
Have filed bankruptcy

Currently in debt

NUTRITIONAL Please describe how many meals you eat per day, any special diet, snacks or food allergies.

Please note any problems you have with the following.

Weight loss in the last 3 months	Yes	No	How much	_____
Weight gain in the last 3 months	Yes	No	How much	_____
Bingeing	Yes	No	Frequency?	_____
Purging	Yes	No	Frequency?	_____
Diuretic Abuse (water pill)	Yes	No		
Laxative Abuse	Yes	No		
Glasses of water or fluid a day	_____			
Do you drink caffeine?	_____		If yes, how much	_____
Nicotine Use (amount per day, duration):	_____			
Abnormal eating habits:	_____			

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ACTIVITIES OF DAILY LIVING

- Independent (I require no assistance from others)
- Minimal Assistance (I require verbal or physical cues/prompts by others)
- Partial Assistance (I require assistance to initiate or complete one or more steps of the process)
- Maximum Assistance (I require assistance at all times to initiate and complete all steps of the process)
- Youth, ability is age specific

LEISURE ACTIVITIES /DAILY ACTIVITIES Describe your hobbies, interests, social life and volunteer work. Please include how you handle stress.

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