Beautiful Minds
MEDICAL, INC.

Adult Personal History

(18 and older)

Patient Name: _____ **DOB:** _____ **Date:** _____

Person completing form for client: _____

Please take your time and complete entire form. The information will help your healthcare provider understand you better. Use the back of the last sheet of this form if necessary.

Reason for seeking help? _____

_____

_____

CIRCLE or CHECK any of the following that apply to you now or within the past month (feel free to explain):

Depression
Crying spells
Hopelessness
Relationship breakup
Loneliness
Emptiness
Loss of appetite
Sleep disturbance
Nightmares
Thoughts of harming self
Thoughts of harming others
Suicide attempts/injuries
Hearing voices
Seeing things others don't
Unusual thoughts

Increased alcohol use
Increased drug usage
Blackouts/memory loss
Withdrawal symptoms
Financial worries
Loss of control in:
- alcohol/drug use
- overeating/bingeing
- purging
- yelling/breaking
- hitting people
- endangering self
- endangering others
- spending
- gambling

Nervous/Anxious
Panic attacks
Can't concentrate
Confusion
Mood swings
Racing thoughts
Fear of dying
Job stress
Decreased activity
Not seeing friends
Feel controlled
Feel talked about
Guilt/shame
Sexual problems
School problems

Ethnicity (circle which one applies): Hispanic or Latin OR Not Hispanic or Latin

Hawaiian or Latin

Race (circle which ones apply):

Asian
Native Hawaiian
Other Pacific Island
Black or African American
White
Hispanic
Other Pacific Islander
Other Race

Physical Health:

Circle the number for each item that applied to you in the past or now:

1. Allergies
2. Asthma
3. Ulcers
4. Cancer
5. Stomach problems
6. Pancreatitis
7. Chronic pain
8. Heart disease
9. Bacterial endocarditis
10. Seizures
11. High Blood Pressure
12. Low Blood Pressure
13. Diabetes
14. Hypoglycemia (Low blood sugar)
15. Thyroid Problems
16. Liver Disease
17. Vision problems
18. Hearing problems
19. Speech problems
20. Dental problems
21. Weight loss
22. Weight gain
23. Severe headaches/migraines
24. Frequent neck/shoulder pain
25. Head injuries
26. Physical Abuse
27. Sexual abuse
28. Premenstrual syndrome
29. Sexually transmitted diseases
30. Positive HIV
31. AIDS
32. Tuberculosis
33. Hepatitis
34. Major surgeries
35. Chronic fatigue syndrome
36. Impotence
37. Prolapsed mitral valve
38. Circulation problems
39. High Cholesterol
40. Irritable bowel
41. Broken bones
42. Accidents
43. _____
44. _____

Please list any surgeries you have had: _____

_____

Allergies (list all): _____

Tobacco Use **Yes / No** How much _____

Caffeine Use **Yes / No** How much _____

Advance Directive **Yes / No**

Flu Shot **Yes / No** Approximate Date _____ Location Administered _____

Pneumococcal vaccine **Yes / No** Approximate Date _____ Location Administered _____

List of Medications:

Medication	Dosage	Directions	Reason for taking