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	Increased alcohol use	Nervous/Anxious
Crying spells	Increased drug usage	Panic attacks
Hopelessness	Blackouts/memory loss	Can't concentrate
Relationship breakup	Withdrawal symptoms	Confusion
Loneliness	Financial worries	Mood swings
Emptiness	Loss of control in:	Racing thoughts
Loss of appetite	- alcohol/drug use	Fear of dying
Sleep disturbance	- overeating/bingeing	Job stress
Nightmares	- purging	Decreased activity
Thoughts of harming self	- yelling/breaking	Not seeing friends
Thoughts of harming others	- hitting people	Feel controlled
Suicide attempts/injuries	- endangering self	Feel talked about
Hearing voices	- endangering others	Guilt/shame
Seeing things others don't	- spending	Sexual problems
Unusual thoughts	- gambling	School problems

ETHNICITY: Circle which one applies: Hispanic or Latin OR Not Hispanic or Latin

Hawaiian or Latin

RACE: Circle which ones apply:

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

Beautiful Minds Medical, Inc.

ADULT PERSONAL HISTORY (18 AND OLDER)

PATIENT NAME: _____ DOB: _____ DATE: _____

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. Sever 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've had:_____

_____

Allergies (Please list all):

_____

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

Caffeine Use **Yes / No** How much_____

Advanced Directive **Yes / No**

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

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

Beautiful Minds Medical, Inc.

ADULT PERSONAL HISTORY (18 AND OLDER)

PATIENT NAME: _____ DOB: _____ DATE: _____

LIST OF MEDICATIONS

Medication	Dosage	Directions	Reason for taking