Sutter Health
Palo Alto Medical Foundation

PATIENT LABEL

ADULT INFORMATION FORM

Please fill out the following information as completely as possible. This will make it unnecessary to ask you routine questions and save time for more important discussions.

Name_____ Date of Birth_____

Address_____

_____

How long have you lived in this area?_____

Occupation_____ How long?_____

Employed by_____ How long at present job?_____

Highest school grade completed_____ Birthplace_____

Married ___Yes ___No How long?_____ Do you live with your spouse? ___Yes ___No

Previous marriages? ___Yes ___No Additional family circumstances we may need to know to help you?

_____

_____

Household Members

Name	Age	Relationship	Occupation/Grade

Family Members Not Living in Household (e.g., stepchildren, adult children, etc.)

Name	Age	Relationship	Occupation/Grade

Please list below family member(s) who have (or had) emotional problems, psychiatric illnesses and/or difficulties with drug or alcohol abuse.

Family Member (relationship to you)	Problem	On-Going	Resolved
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

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Describe the problems that are causing you to seek help.

How long have these problems bothered you?

What do you consider your strengths and resources?

Have you ever had psychotherapy or counseling before? ☐ Yes ☐ No
If yes, please list psychotherapist(s) and dates and type (individual, family, couple, group) of treatment:

Have you ever had medication prescribed for psychiatric or emotional difficulties? ☐ Yes ☐ No
If so, please list all such medications, their dosages, and when you took them.

What medications of **any kind** are you currently taking?

Medication	Frequency	Dosage	What For

Have you had allergic reactions or other problems with medications? ☐ Yes ☐ No
If yes, which drugs, and briefly explain.

What medical problems do you have and dates of surgeries?

Have you had any legal difficulties?

Have you ever had a problem with alcohol or drugs?

Is there any other information we should know to help you?