Adult Self-Report of History Form

Patient Name: _____ Date of Birth: _____ Date Form Completed: ____

How do you prefer to be addressed? _____

Gender Identity: _____ Preferred Pronouns: _____

Identity

Please list anything that you believe to be important in appreciating your sense of identity (ethnic, cultural, religious/spiritual, gender, sexual preference, etc.):

Reason for Seeking Services

Please describe what it is you are seeking help for.

Current Living Arrangements / Relationships / Family

Relationship Status (Please circle as applicable):

Single/never married Single/divorced Single/cohabitating

Married Separated Widowed Other/please specify_____

Number of times Married ____ Number of times Divorced _____

Living Status (Please circle those that apply):

Living alone Living with roommate(s) Living with spouse/significant other

Living with children Living apart from children Living with parents

Living with caretaker/guardians

Other arrangement/please specify _____

Biological children? Yes / No If yes, please list their names/ages.

Step or Adoptive children? Yes / No If yes, please list their names/ages.

Family of Origin

Parents and/or Primary Caregivers when you were growing up:

Parent or Caregiver's Name	Role (Mother, Father, Step, Foster, Grandparent, etc.)	Current age if living	Highest Education & Occupation

How many siblings do you have? (please also note step and half siblings)

What was your birth order in your family of origin? _____

Please describe anything notable about any of your siblings.

Developmental History

Are you aware of having experienced any developmental delays or difficulties in the following areas:

Speech Yes/No If yes, please describe.

Fine Motor Yes/No If yes, please describe.

Gross Motor Yes/No If yes, please describe.

Social Skills Yes/No If yes, please describe.

Learning Disability Yes/No If yes, please describe.

Other Difficulties Yes/No If yes, please describe.

Please continue on next page →

Please note if you have experienced any of the following types of trauma/victimization

	Ages	Please describe
Physical Abuse or Assault		
Sexual Abuse/ Molestation		
Rape		
Emotional Abuse		
Emotional Neglect		
Other Traumatic Experience		

Sexual History

Please check the following that apply

Not sexually active in the past _____ Sexually active in the past ____

Not sexually active presently _____ Sexually active presently _____

How do you describe your sexual preference? _____

Have you been exposed to or at risk for exposure to any sexually transmitted diseases? Yes / No

If yes, please describe:

Education and Employment

What is the highest level of education you have attained? Please specify major areas(s) of study and anything else you would like to highlight.

If employed currently, when did you begin? _____

Please describe your position (including employer, nature of your work) and the quality of work, your work relationships, and how meaningful the work is to you.

Please list previous employment, approximate dates, and reasons for ending. Feel free to comment on how meaningful the work is to you.

Hobbies and Recreational Interests

Please list your current hobbies, leisure, and recreational activities. Please note if there are any enjoyable activities you have lost interest in or otherwise no longer engage in.

Legal Involvement

Have you ever been involved in legal proceedings? Yes / No If Yes, please describe.

Have you ever been prosecuted or convicted? Yes / No If Yes, please describe.

Religious and Cultural Factors

Religious/Spiritual Affiliation:

Are you currently active in the practice of your religion? Yes / No

If yes, do you belong to and/or participate in a religious congregation? Yes / No

Are you presently experiencing a religious or spiritual crisis? Yes / No If Yes, please describe.

Do you have any cultural or personal preferences that will be important for Dr. Bram to be aware of?

Yes / No If Yes, please circle all that apply and elaborate below:

Appearance Custom Diet Dress Ritual Other, please specify_____

Is English your second language? Yes / No If Yes, what is your primary language?

Social and Financial Circumstances

Please note if you have had difficulty in any of the following areas in the past year.

Housing	Yes / No	If Yes, please describe.
Food security	Yes / No	If Yes, please describe.
Financial status/Annual income	Yes / No	If Yes, please describe.
Access to health care and social services	Yes / No	If Yes, please describe.
Access to social contacts	Yes / No	If Yes, please describe.
Vulnerability to victimization/discrimination	Yes / No	If Yes, please describe.
Other, Specify _____	Yes / No	If Yes, please describe.

Mental Health History

Have you experienced any emotional difficulties prior to the present challenges?

Yes / No If Yes, please describe.

Please list your current medications (both psychiatric and medical, prescription and over-the-counter medications taken in the last week).

Name of Medication & approximate date begun	Dosage	Frequency	Targeted Symptoms

Please list previous psychiatric medications that have been tried before, approximate dates, and reasons they were discontinued (such as negative reaction, side effects, ineffectiveness):

Please note if you have ever engaged in any of the following behaviors:

Behavior	Yes/No	If yes, please describe (include how recently and approximate ages)
Intentionally harmed yourself?		
Thought about suicide		
Talked about or threatened suicide?		
Attempted suicide?		
Threatened physical violence?		
Bullied others?		
Seriously thought about hurting or killing someone?		
Tried to physically hurt or kill someone?		
Intentionally killed or injured a pet or other animal?		
Been in trouble with the law or engaged in illegal behaviors even you did not get caught?		

***Current* Mental Health Treatment**

Are you currently receiving mental health services from anyone in addition to Dr. Bram (such as another psychologist, a psychiatrist, social worker, school counselor, etc.)? Yes / No

If No, please skip to Past Mental Health Treatment

If Yes, please note the name(s) of the clinician(s), when the treatment began, and the type and frequency of treatment (for example, psychodynamic therapy, psychoanalysis, cognitive-behavioral therapy [CBT], dialectical behavior therapy [DBT]), medication management, family therapy, partial hospital, intensive in-home therapy).

Name of Clinician and/or Program	**Approximate Date Begun**	**Type and Frequency of Treatment**

Please share briefly what has been most helpful and least helpful about current treatment:

***Past* Mental Health Treatment**

Previous Treatment (include approximate ages)	**Frequency and Length of Treatment**	**Generally Helpful? (Yes / No)**	**Name of Clinician and/or Program**
Outpatient (specify individual, family, or group therapy)			
Inpatient Psychiatric Hospital			
Residential Treatment			
Partial Hospital / Day Treatment Program			
12-Step/Self-Help Groups or Program(s)			
Other			

Please share briefly what has been most helpful and least helpful about past treatment:

Medical History

Please note the name of your primary care physician and their facility: _____

Approximate date of your most recent physical examination: _____

Please describe if there were notable findings or recommendations from that physical examination.

Please describe your past and ongoing physical health:

	Yes/ No	Past or Current	Please specify and describe (include approximate dates, treatment, and effectiveness)
Major physical illness			
Head injury			
Other major injury			
Seizures			
Headaches			
Operations/Surgeries			
Other major medical treatments (note if inpatient or outpatient procedures)			
Allergies			
Problems related to sleep			
Other			

Please describe your immunization status (include Covid-19 boosters).

Substance Use History

Please complete for only categories that you have used:

Category	Type of Substance	Age Started	Date of Last Use	Current Use (Amount & Frequency)	Use at Most Extreme (Approx dates, Amount, Frequency)
Tobacco					
Alcohol					
Prescription medications					
Over-the-counter medication					
Marijuana					
Cocaine					
Narcotics					
Sedatives					
Amphetamine (or similar)					
Hallucinogens					
Inhalants					
Other					

Have you received treatment for problematic alcohol or substance use? Yes / No

If Yes, please specify what kind of treatment (such as AA, intensive outpatient, inpatient detox) residential, length, and approximate dates. Also, describe how helpful such treatments have been.

If No, have you, a family member, friend, etc. been concerned about your alcohol or substance use? Yes / No

If Yes, please elaborate (including how recently).

Family Psychiatric and Medical History

Has anyone in your family been diagnosed with a mental health problem (such as depression, ADHD, bipolar illness, schizophrenia, etc.)? Yes / No

- If Yes, please specify the condition and the relative's relationship to you (for example, maternal uncle, paternal grandmother, cousin on father's side)?

Is there anyone in your family who has been suspected of having a mental health condition, even if they have not been formally diagnosed or treated? Yes / No

- If Yes, please specify the symptoms/suspected condition and the relative's relationship to you c (for example, maternal uncle - anxiety, paternal grandmother - depression, cousin on father's side - autism)?

Has anyone in your family had problems with drugs, alcohol, or other addictions? Yes / No

- If Yes, please describe, along with the relative's relationship to you:

Has anyone in your family had a major medical illness Yes / No

- If Yes, please describe.

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Please complete the Mood Questionnaire on the Next Page

Brief Mood Screening Questionnaire

Below is a list of some ways you may have felt or behaved. Please indicate how often you have felt this way during the last week by checking the appropriate space. Please only provide one answer to each question.

	During the past week:	***Rarely*** or none of the time (less than 1 day)	***Some*** or a *little* of the time (1-2 days)	***Occasionally*** or a moderate amount of time (3-4 days)	***Most*** or all of the time (5-7 days)
1.	I was bothered by things that usually don't bother me.				
2.	I did not feel like eating; my appetite was poor.				
3.	I felt that I could not shake off the blues even with help from my family or friends.				
4.	I felt I was just as good as other people.				
5.	I had trouble keeping my mind on what I was doing.				
6.	I felt depressed.				
7.	I felt that everything I did was an effort.				
8.	I felt hopeful about the future.				
9.	I thought my life had been a failure.				
10.	I felt fearful.				
11.	My sleep was restless.				
12.	I was happy.				
13.	I talked less than usual.				
14.	I felt lonely.				
15.	People were unfriendly.				
16.	I enjoyed life.				
17.	I had crying spells.				
18.	I felt sad.				
19.	I felt that people disliked me.				
20.	I could not get going.				

In the past few weeks,

1. have you wished you were dead? Yes / No

2. In the past few weeks, have you felt that you or your family would be better off if you were dead?

   Yes / No

3. In the past week, have you been having thoughts about killing yourself? Yes / No

4. Have you ever tried to kill yourself? Yes / No

   If Yes, how? _____

   When? _____

5. Are you having thoughts of killing yourself right now? Yes / No If Yes, please describe:

If you are currently feeling suicidal and at risk of acting on such feelings, please call 911 or go to the emergency room at the nearest hospital.