# Client Information and History

Adult Version

**Patient Information:** Today's Date: _____

Name: _____ DOB: _____ Age: _____

Nickname:_____ Gender: Male ☐ Female ☐ Handedness: _____

Marital Status: Single ☐ In a relationship ☐ Married ☐

Widowed ☐ Separated ☐ Divorced ☐ Other: ☐ _____

Street Address: _____

City/State/Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Email Address*: _____ *Email is not a secure form of communication

Please initial if it is okay to communicate by email regarding appointments, info related to treatment, clinic updates/newsletters _____

Which method of communication do you prefer? Cell ☐ Home ☐ Work ☐ Other: ☐ _____

Is it okay to leave a message on: All numbers ☐ Cell ☐ Home ☐ Work ☐ Other: ☐ _____

Emergency Contact #1: _____ Relationship? _____ Phone #: _____

Emergency Contact #2: _____ Relationship? _____ Phone #: _____

**Medical & Mental Health Information:**

Physician: _____ Phone #: _____

Address: _____

Permission to contact Physician? Yes ☐ No ☐

Are you currently being treated for any medical conditions? If so, please describe: _____

_____

_____

_____

Have you ever seen a Psychiatrist or any other mental health provider? Yes ☐ No ☐

If yes, When? _____ Focus of treatment? _____

_____ Helpful? Yes ☐ No ☐

When was you last eye exam? _____

When was you last physical exam? _____

Your sleep patterns (*please circle all that apply*): Restless ☐ Nightmares ☐ Night Terrors ☐ Other_____

What time do you: Go to bed? _____ Get up? _____

Do you sleep through the night? Yes ☐ No ☐

Have there been previous evaluations? By whom? Results? _____

_____

_____

_____

_____

Can we obtain copies of results? Yes ☐ No ☐

What brought you in today? _____

_____

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How long have you been experiencing this problem? _____
_____

Have you received any treatments for this problem? Yes ☐ No ☐ If so, what? _____
Why was it not successful?_____
_____
_____
_____

How will you know if we have been helpful? _____
_____
_____

How did you find out about Oxford Recovery Center?
☐ Radio (WMUZ) Bob Dutko _____ Chris Stevenson_____ Robin Sullivan _____
☐ WJR (760 AM) Host: _____
☐ Radio 1300 AM
☐ Internet/Website
☐ Physician Name:_____ Specialty: _____ Phone#: _____
☐ WDIV/Channel 4 commercial
☐ Friend/Relative
☐ Other

## Personal and Family History

Have you or any of your parents, grandparents, siblings, and parents' siblings had any of the following?
(If you are adopted, answer to reflect birth parents and birth siblings to whatever degree you have access to).

| Symptoms | Client | Family Member(s) |
|---|---|---|
| **As a child:** | | |
| "Rocker" | Yes ☐ No ☐ | _____ |
| Considered to be a difficult child | Yes ☐ No ☐ | _____ |
| Developmental delays: coordination, walking, speech, etc. | Yes ☐ No ☐ | _____ |
| Bedwetting after age 5 | Yes ☐ No ☐ | _____ |
| Head banging | Yes ☐ No ☐ | _____ |
| Sleep walking or night terrors | Yes ☐ No ☐ | _____ |
| Learning Disability | Yes ☐ No ☐ | _____ |
| Difficulty learning: reading, writing, math | Yes ☐ No ☐ | _____ |
| Behavioral problems in school | Yes ☐ No ☐ | _____ |
| Truancy | Yes ☐ No ☐ | _____ |
| Held back in school/repeated grade | Yes ☐ No ☐ | _____ |
| Considered bright, but unmotivated | Yes ☐ No ☐ | _____ |
| Achieved less academically/professionally than parents/siblings | Yes ☐ No ☐ | _____ |
| Underachiever in school, sports, work, or social life | Yes ☐ No ☐ | _____ |
| ADD, ADHD | Yes ☐ No ☐ | _____ |
| Tourette syndrome | Yes ☐ No ☐ | _____ |
| Seizure Disorder | Yes ☐ No ☐ | _____ |
| Conduct Disorder | Yes ☐ No ☐ | _____ |

**Personal and Family History continued…**

| **Symptoms** | | **Client** | **Family Member(s)** |
|---|---|---|---|
| **In the past or currently:** | | | |
| Oppositional/Defiant Disorder | | Yes ☐ No ☐ | _____ |
| Frequent fights | | Yes ☐ No ☐ | _____ |
| Few/or no friends, a loner | | Yes ☐ No ☐ | _____ |
| Fire setting | | Yes ☐ No ☐ | _____ |
| Temper tantrums | | Yes ☐ No ☐ | _____ |
| Depression or Manic Depression | | Yes ☐ No ☐ | _____ |
| Anxiety/Panic Attacks | | Yes ☐ No ☐ | _____ |
| Emotional problems | | Yes ☐ No ☐ | _____ |
| Excessive or inappropriate use of alcohol | | Yes ☐ No ☐ | _____ |
| Use of illegal drugs | | Yes ☐ No ☐ | _____ |
| Excessive use of prescription or over the counter drugs | | Yes ☐ No ☐ | _____ |
| Nicotine use or dependence | | Yes ☐ No ☐ | _____ |
| Uses caffeine more than 1 or 2 cups | | Yes ☐ No ☐ | _____ |
| Obesity or eating disorder | | Yes ☐ No ☐ | _____ |
| Problem habit: | Pornography | Yes ☐ No ☐ | _____ |
| | Nail biting | Yes ☐ No ☐ | _____ |
| | Masturbation | Yes ☐ No ☐ | _____ |
| | Compulsive self-injury | Yes ☐ No ☐ | _____ |
| Workaholism | | Yes ☐ No ☐ | _____ |
| Gambling | | Yes ☐ No ☐ | _____ |
| Risk-taking behaviors | | Yes ☐ No ☐ | _____ |
| Problems with the law | | Yes ☐ No ☐ | _____ |
| Bankruptcy/excessive debt/bad checks | | Yes ☐ No ☐ | _____ |
| Premenstrual Syndrome | | Yes ☐ No ☐ | _____ |
| Irritable Bowel Syndrome | | Yes ☐ No ☐ | _____ |
| Frequent gas or diarrhea | | Yes ☐ No ☐ | _____ |
| Migraines | | Yes ☐ No ☐ | _____ |
| High blood pressure | | Yes ☐ No ☐ | _____ |
| Reacts to drugs differently than others | | Yes ☐ No ☐ | _____ |
| Asthma or frequent respiratory infections | | Yes ☐ No ☐ | _____ |
| Skin blotching under stress | | Yes ☐ No ☐ | _____ |
| Class clown | | Yes ☐ No ☐ | _____ |
| Unusually sensitive to light, noise, touch, etc. | | Yes ☐ No ☐ | _____ |
| Allergies | | Yes ☐ No ☐ | _____ |

**In addition, have you experienced**:

Numerous ear infections? Yes ☐ No ☐ Frequent earaches? Yes ☐ No ☐

Mixed left/right dominance for handedness? Yes ☐ No ☐

Unusually sensitive to light, noise, touch, etc.? Yes ☐ No ☐

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## Medical History of Client:

1. 1-3 months prior to pregnancy were either of your birth parents using drugs (legal or illegal; alcohol, nicotine)? Yes ☐ No ☐
2. During the pregnancy, did your birth mother use drugs (legal or illegal; alcohol, nicotine)? Yes ☐ No ☐
3. Were there any complications during the pregnancy? _____
4. Were there any complications during the delivery? _____
5. Were there any complications during neonatal period? _____
6. Did you have colic or feeding problems in infancy? _____
7. Have you ever had *any* head injury? Yes ☐ No ☐

   Have you client ever had *any* loss of consciousness? Yes ☐ No ☐

   If yes to either question, please rate the severity of the following symptoms on a scale of 0 to 8 (8 being severe)

   _____ Have had one or more concussions
   _____ Have mild headaches
   _____ Experiences loss of balance, dizziness and/or unsteady walking
   _____ Problems with memory
   _____ Have difficulty organizing daily activities
   _____ Have difficulty making decisions/solving problems
   _____ Gets lost easily
   _____ Tired all the time
   _____ Moodiness

8. Have you ever had a stroke? Yes ☐ No ☐
9. Have you experienced long-term use of medication? Yes ☐ No ☐

   If yes, what? _____
   _____
   _____
   _____
   _____
10. Have you experienced severe illness, hospitalization or surgery? Explain. _____
    _____
    _____
    _____
    _____
    _____

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11. Have you ever been diagnosed with an autoimmune disorder (see list below):

| | | | |
|---|---|---|---|
| Chronic Fatigue Syndrome | Yes ☐ No ☐ | Scleroderma | Yes ☐ No ☐ |
| Fibromyalgia | Yes ☐ No ☐ | Epstein - Barr virus | Yes ☐ No ☐ |
| Lupus | Yes ☐ No ☐ | Other | Yes ☐ No ☐ |
| Hashimoto's Thyroiditis | Yes ☐ No ☐ | If yes, what? _____ | |

If yes to any above, please describe nature of symptom and rate severity on scale of 0 to 8 (8 being most severe).

| **Symptom** | **Rating** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

12. Have you ever been diagnosed with any of the following disorders?

| | | | |
|---|---|---|---|
| Cerebral Palsy | Yes ☐ No ☐ | Migraines | Yes ☐ No ☐ |
| Environmental Toxin Syndrome | Yes ☐ No ☐ | Multiple Sclerosis | Yes ☐ No ☐ |
| (Due to black mold, carbon monoxide, chemicals or inhalants) | | Parkinson's | Yes ☐ No ☐ |
| Fetal Alcohol Syndrome | Yes ☐ No ☐ | Asperger's Syndrome | Yes ☐ No ☐ |
| Hypoxia | Yes ☐ No ☐ | Autism | Yes ☐ No ☐ |

If yes to any above, please describe nature of symptom and rate severity on scale of 0 to 8 (8 being most severe).

| **Symptom** | **Rating** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |