



**Adult Partial Hospitalization Program  
PATIENT'S PERSONAL HISTORY**

Reviewed By: \_\_\_\_\_ MD / DO  
Date: \_\_\_\_\_

Although psychiatry personnel primarily focus on treating mental health, any physical health concerns you may have, medications you may be taking, and your personal background can have a significant interrelationship with the treatment you will receive. All your information will remain confidential. Thank you for answering the following questions as you are able:

1.) Briefly describe your reason for seeking treatment:

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**MEDICAL BACKGROUND:**

2.) Check any items below that you have problems with:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Intestinal/Digestion	<input type="checkbox"/> Seizures	<input type="checkbox"/> Special Diets
<input type="checkbox"/> Cancer	<input type="checkbox"/> Falls Risk	<input type="checkbox"/> Liver	<input type="checkbox"/> Sexual Diseases	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Head/Neck Injury	<input type="checkbox"/> Migraines	<input type="checkbox"/> Sexual Function	<input type="checkbox"/> Tremors
<input type="checkbox"/> Circulation /Cardiac	<input type="checkbox"/> Headaches	<input type="checkbox"/> Muscle	<input type="checkbox"/> Skeletal	<input type="checkbox"/> Urinary/Kidney
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Reproductive	<input type="checkbox"/> Skin	<input type="checkbox"/> Other
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Infections	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Sleep/Sleep Aids	

3.) Describe ALL items checked above:

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4.) List ALL PREVIOUS SURGERIES and approximate date of each:

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**CULTURAL BACKGROUND:**

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18.) Do you identify with any particular cultural background(s), religion(s), ethnicities, spirituality, and/or sexual orientation(s)?  NO  YES If yes, please describe:

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19.) How significant a role does religion play in your life?

- Very important     Somewhat important     Minor importance     Not important

20.) Are there any spiritual/religious/cultural/ethnic/sexuality matters which might impact treatment or that you want us to know about:  NO  YES If yes, describe:

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**EDUCATION:**

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21.) Highest Grade Completed:  GED  HS Diploma  Associate  Bachelors  Masters  Ph.D  Other:

22.) Preferred Way to Learn:  Audio  Video  Verbal Explanation  Written Handout  Demo/Practice

23.) Did you attend Special Education classes during school ?  NO  YES

24.) Are there any educational/school-related issues which might impact treatment or that you want us to know about?

NO  YES If yes, describe:

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**MILITARY SERVICE:**

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25.) Have you served in the military?  NO  YES If yes, which branch of service:

26.) Are there any military service issues which might impact treatment or that you want us to know about (ex. Tours of Duty, Medical Discharge):  NO  YES If yes, describe:

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**LEISURE AND RECREATION:**

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27.) List what you like to do for leisure and recreation:

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**PATIENT STRENGTHS AND WEAKNESSES:**

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28.) List several of your strengths:

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29.) List any of your potential weaknesses:

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**Please add any additional information that you would like us to know in regard to your health and your desired treatment:**

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