Print Form

Family Psychology Associates

Strengthening relationships…improving lives.

SENIOR HISTORY FORM

Date:_____

Name:_____ DOB:_____ Age:_____ Gender: F____M____

Current Residence:_____

Place of Birth:_____ Education:_____ E-mail:_____

Marital Status: Single_____ Married_____ Spouse's Name_____

Separated_____ Divorced_____ Widowed_____ Other_____

Total # Marriages_____ Total # Divorces_____ Total # Widowing_____

Major Life's Work:_____

Currently Employed? No___ Yes___ Type Work:_____

Household Members:

Name	Age	Grade/Occupation	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL INFORMATION:

Are you currently under a physician's care? No____ Yes____

Who is your Primary Care Physician?_____

Other physician's involved in your care:_____

When was your last physical examination?_____

Current health problems or symptoms:_____

If you have any allergies or adverse reactions to particular drugs or substances, please specify:_____

Medications you are currently using and why:

Medication	Dosage	Prescribing Physician	Reason for use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past treatments for medical problems, accidents or injuries:_____

Would you like us to contact your physician or send him/her a copy of your treatment plan? No__ Yes__

If so, please supply the physician's name and phone or fax number:_____

Do you have any history of problems related to alcohol or drug use? If so, please specify:_____

Current alcohol/drug use: Substance used:_____ Frequency of use:_____

Have you ever felt you should cut down on your substance use? No____ Yes____

Have people annoyed you by criticizing your substance use? No____ Yes____

Have you ever felt bad or guilty about your substance use? No____ Yes____

Have you ever used the substance first thing in the morning to steady your nerves? No____ Yes____

LEGAL INFORMATION:

Do you have a designated Health Care Surrogate? No____ Yes____ Name:_____

Do you have a Legal Guardian? No____ Yes____ Name:_____

Do you have a Living Will? No____ Yes____

Do you have Advance Medical Directives in writing? No____ Yes____

Do you have an Elder Care Attorney? No____ Yes____

Do you have any history of, or current involvement in, court proceedings? (e.g. divorce litigation, arrests or convictions for other than minor offenses) _____

PSYCHOLOGICAL INFORMATION:

Have you been seen previously by a Psychologist, Psychiatrist or other mental health professional?
No____ Yes____ Name of clinician:_____

Address and phone # if known:_____

When?_____ Reason for prior treatment:_____

Have you ever been hospitalized for treatment of emotional or substance abuse problems?

No____ Yes____ If so, where and
when?_____

Do you have a history of: Sexual Abuse_____ Physical Abuse_____ Emotional Abuse_____

Other Trauma (specify)_____

Are there any spiritual or cultural issues that might affect your treatment?_____

Why are you seeking services from Family Psychology Associates at this time?_____