



Reclaim Mental Health, LLC

Akiva Daum, MD FAPA

Board Certified General and Addiction Psychiatry

www.reclaimmh.com

3275 W Hillsboro Blvd, Suite 300D

Deerfield Beach, FL 33442

Phone: (954) 451-2592

Fax: (888) 490-0705

ADULT HISTORY QUESTIONNAIRE

(Please be as descriptive as possible. If you are not comfortable writing information, you can certainly share it in session. The more we know about where you struggle, the more we can offer assistance)

Date _____

Date of Birth _____

Name _____

Age _____

Presenting problem _____

Early Childhood Information

Complications or unusual events at birth _____

Any delays in developmental milestones _____

Details about growing up: _____

Parents: Married ☐ Never Married ☐ Divorced ☐ Separated ☐ Other ☐

Mark if living Mother ☐ Father ☐

Quality of their relationship? _____

Adopted ☐ If so, do you know about your biological parents? _____

How do you relate to your mother?

How do you relate to your father?

Do you have siblings Yes ☐ No ☐

Do any siblings have disabilities or developmental problems Yes ☐ No ☐

Describe your childhood

Describe your adolescence



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Any traumatic events Yes ☐ No ☐

If yes:

Other significant information

Medical History

Medical Hospitalizations Yes ☐ No ☐ Psychiatric Hospitalizations Yes ☐ No ☐ Residential, PHP, IOP Yes ☐ No ☐

If so, what for? _____

☐ Hepatitis C ☐ History of strokes ☐ Heart disease ☐ High blood pressure ☐ Diabetes

☐ Chronic Pain ☐ Seizure Disorder ☐ Nutritional issues ☐ History of heart attack ☐ Anemia

☐ Sleep disorder ☐ Fertility issues ☐ Bleeding disorder ☐ High cholesterol

☐ other _____

Allergies _____

Current Medications _____



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Primary Care Provider _____

Previous psychiatric care Yes [] No [] Psychotherapy Yes [] No [] When _____

With whom _____

Eating problems Yes [] No []

If so, please elaborate _____

Sleeping problems Yes [] No []

If so, please elaborate _____

History of suicide attempts Yes [] No []

History of self-injurious behaviors Yes [] No []

If so, please elaborate _____

Do you currently have suicidal thoughts Yes [] No []

If so, please elaborate _____

Do you have a history of physical/emotional/sexual abuse or trauma Yes [] No []

If so, please elaborate _____

Is there other information you think I should know _____

Family history of mental illness _____



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Substance Use

Are you a tobacco user? Yes ☐ No ☐ Do you vape nicotine? Yes ☐ No ☐

Would you like to quit? Yes ☐ No ☐ Unsure ☐ Other _____

Alcohol Yes ☐ No ☐

If so, please elaborate _____

Cannabis Yes ☐ No ☐

If so, please elaborate _____

Sedatives (Benzodiazepines, Muscle relaxers, etc) Yes ☐ No ☐

If so, please elaborate _____

Opioids Yes ☐ No ☐

If so, please elaborate _____

Cocaine Yes ☐ No ☐

If so, please elaborate _____

Hallucinogens Yes ☐ No ☐

If so, please elaborate _____

Is there other information you think I should know _____



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School History

Last grade completed in school _____ When _____

Type of student/grades _____

Any identified learning problems Yes ☐ No ☐

If so, please elaborate _____

Any suspensions/expulsions/behavioral issues Yes ☐ No ☐

If so, please elaborate _____

Is there other information you think I should know _____

Work/Social/Military/Legal History

Current Job: _____ How long have you worked there _____

Prior jobs _____ Longest Employment _____

Marital History _____

Longest relationship _____

Children Yes ☐ No ☐ If yes, ages _____

Military Service Yes ☐ No ☐

If so, please elaborate _____



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Have you ever been arrested Yes [] No []

If so, please elaborate _____

Social activities _____

How many friends do you have _____ How many close friends _____

Hobbies _____

Is there other information you think I should know _____

What do you want to gain from treatment _____

Other information you wish to share _____
