

Ben C. Ghozali, Psy.D., P.A.

Licensed Psychologist

Adult History Form

Date: _____

Name: _____ Age: _____ DOB: _____

Education: _____ Occupation: _____

Marital Status: Married _____ Separated _____ Widowed _____ Other _____
Date married _____ Date Separated/Divorced _____ Date remarried _____

Other Family Members:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who is your primary physician? _____

Current medical/physical problems: _____

Are you currently treated by a psychiatrist? If so, who? _____

Please list any medications that you are taking:	Dosage:	What for:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you notice any side effects? _____

Please list any previous medications you have been prescribed in the past and why it was discontinued:

What are the primary concerns that led you to making an appointment? _____

How long have you been experiencing these issues? Briefly describe the onset of these issues. _____

Have you engaged in treatment previously? Briefly describe the reasons for treatment and the outcome. _____

Describe your goals for treatment: _____

Has anything happened that may have caused and/or contributed to the emotional/behavioral problems that you are experiencing? _____

Are there any legal issues currently affecting you (e.g. divorce, custody, criminal activities, etc.)? _____

Signature: _____