THE HAUSER CLINIC AND ASSOCIATES ACCT #_____
PATIENT HISTORY- **PLEASE COMPLETE BOTH SIDES**

Name: _____ Birthdate: ____/____/____ Today's Date: ____/____/____

Marital Status
☐Single ☐Significant Other
☐Married ☐Separated
☐Divorced ☐Widowed

Education (highest level attained)
☐GED ☐High School Grad
☐College Grad ☐Grad Degree
☐Other _____

Military History
☐Army Served from _____ to _____
☐Navy Rank: _____
☐Air Force Type of Discharge: _____
☐Marines Specialty/MOS: _____
☐Coast Guard

Religious Affiliation

Legal History
Have you been convicted of a misdemeanor or felony? ☐Yes ☐No
If yes, provide details of all convictions: _____
_____

REASON FOR APPOINTMENT (Please check all that apply)
☐Alcohol ☐Drugs ☐Marital/Sexual Issues ☐Sexual Abuse
☐Anxiety ☐Eating Disorder ☐Panic Attack ☐Stress
☐Behavior Problem ☐Family Issues ☐Physical Abuse ☐Suicidal Thoughts
☐Bipolar ☐Legal Issues ☐Problem at Work ☐Other _____
☐Depression ☐Manic ☐School Problems

Family History	Name	Age	If deceased, cause of death	Age at Death
Father				
Mother				
Brothers and/or Sisters	1.			
	2.			
	3.			
	4.			
	5.			
Husband or Wife				
Children	1.			
	2			
	3.			
	4.			
	5.			

List any drug allergies: _____

Current medications (specify type)
☐Anxiety_____ ☐Depression_____ ☐Sleeping Pills _____
☐Aspirin ☐Diet _____ ☐Tranquilizer_____
☐Birth Control ☐Diuretic_____ ☐Vitamins_____
☐Blood Pressure_____ ☐Hormones_____ ☐_____
☐Cold/Allergy_____ ☐Laxatives_____ ☐_____
☐Cortisone ☐Nasal spray_____ ☐_____
☐Decongestant_____ ☐Pain pills_____ ☐_____

Have you or any blood relatives ever had any of the following?

	Self	Other	(If other, Who?)
Alcoholism	☐	☐	
Anxiety	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Bipolar Illness	☐	☐	
Bowel disease	☐	☐	
Cancer	☐	☐	
Depression	☐	☐	
Diabetes	☐	☐	
Drug abuse	☐	☐	
Emphysema	☐	☐	
Epilepsy	☐	☐	
Headaches	☐	☐	
Heart disease	☐	☐	
High Blood Pressure	☐	☐	
HIV	☐	☐	
Kidney disease	☐	☐	
Liver disease	☐	☐	
Physical abuse	☐	☐	
Schizophrenia	☐	☐	
Sexual abuse	☐	☐	
Stroke	☐	☐	
Suicide/attempt	☐	☐	
Thyroid disease	☐	☐	
Ulcer	☐	☐	

List for all counseling, therapy, illness, injury or surgery:

Date	Reason	Counselor/Therapist/Physician	Hospital, if hospitalized

ACCT #_____

Name: _____ Birthdate: ____/____/____

Have you had complications from childhood diseases? ☐ No ☐Yes_____
Date of last physical examination: ____/____/____ Date of last chest x-ray ____/____/____
Date of last electrocardiogram ____/____/____ Date of last blood test ____/____/____

For Women Only
Menstrual History: Age at onset: _____ Date of last period: ____/____/____ Cycle: ____ days Duration: ____days
Regular ☐ Yes ☐No Pains or cramps ☐ Yes ☐No Premenstrual symptoms ☐ Yes ☐No
Pregnancies: Total number of pregnancies: _____ Miscarriages: _____ Terminations: _____ Age of youngest living child: _____

For Children Only
Were there any prenatal problems? ☐ No ☐Yes_____
Were there any labor or delivery problems? ☐ No ☐Yes_____
Was the child ☐ Full-term or ☐ Premature (if so, weeks premature: _____) Was child ☐breast or bottle fed?
Were the child's developmental milestones within normal limits? Sitting: ☐ Yes ☐No, Crawling: ☐Yes ☐No;
Pullup: ☐ Yes ☐No, Walking: ☐ Yes ☐No; Talking: ☐Yes ☐No. What age was child trained for bladder _____ bowel _____
Did the child wet the bed? ☐ Yes ☐No Who provided early child care?_____
Were there separation problems when the child entered school? ☐ Yes ☐No

Diet and Exercise
Weight: Current: _____; 1 Year Ago: _____; Desired: _____; Are you on a special diet? ☐ No ☐Yes, explain_____
Height: _____ ' _____" Do you exercise: ☐ No ☐Yes, your routine_____

Habits
Coffee/Tea/Caffeinated soft drinks: _____ per day
Do you smoke? ☐ No ☐Yes _____Cigarettes/day _____Cigars/week _____Pipe/day Age began _____ Age stopped _____
Do you use any other form of tobacco? ☐ No ☐Yes Type and frequency_____
How often do you drink alcohol? ☐ Never or How many drinks/wk: ☐1-7 ☐8-15 ☐16-24 ☐more than 24
Have you ever abused or used drugs recreationally? ☐No ☐Yes ☐Marijuana ☐Crack/cocaine ☐Heroin ☐ Sleeping pills
☐Pain medication ☐Other_____ Have you been treated for ☐alcohol or ☐drug abuse/dependency?

Indicate which of the following symptoms you have experienced:

☐Fatigue/lack of energy	☐Seeing things that are not real	☐Double vision	☐Diarrhea
☐Weakness	☐Hearing things that are not real	☐Difficulty in focusing vision	☐Constipation
☐Lack of sleep	☐Difficulty making decisions	☐Eye pain	☐Indigestion/heartburn
☐Sleeping too much	☐Difficulty concentrating	☐Eye discomfort in bright light	☐Vomiting
☐Increase/decrease in appetite	☐Memory problems	☐Sinus pain or congestion	☐Rectal bleeding
☐Increase/decrease in weight	☐Worthless feelings	☐Increase/decrease in tearing	☐Black, tarry stools
☐Repetitive/senseless thoughts	☐Excessive guilt feelings	☐Increased sensitivity to sounds	☐Food Intolerance
☐Repetitive/senseless behavior	☐Hopeless feelings	☐Ear Infections	☐Inability to control bowels
☐Sad/down in the dumps	☐Helpless feelings	☐Joint pain or stiffness	☐Fear of losing bowel control
☐Depressed	☐Sweating	☐Backache	☐Hay fever, allergies
☐Irritability/anger	☐Dizziness/light headedness	☐Muscle tension	☐Cough/ coughing up blood
☐Nervousness	☐Unsteady feelings	☐Muscle pain/soreness	☐Wheezing
☐Fearful feelings	☐Jumpiness	☐Swelling of hands/feet/ankles	☐Shortness of breath
☐Frequent crying	☐Keyed up/on edge	☐Leg cramps	☐Dry mouth
☐Frequent negative thinking	☐Restlessness	☐Numbness/tingling in limbs	☐Unusual taste sensations
☐Frequent thoughts of death	☐Constant worry	☐Foot problems	☐Frequent/painful urination
☐Suicidal thoughts	☐Panic	☐Trouble walking	☐Inability to control urine
☐Homicidal thoughts	☐Feeling life not worth living	☐Balance problems	☐Penile/vaginal discharge
☐Fainting, feeling faint	☐Increase/decrease in sex drive	☐Cold/clammy hands	☐Penile/vaginal sores
☐Tremors	☐Fear of going crazy	☐Unable to sit still	☐Difficulty in sexual function
☐Trembling or shakiness	☐Fear of dying	☐Chest pain/discomfort	☐Breast discharge
☐Seizures/convulsions	☐Feelings of unreality	☐Palpitations	☐_____
☐Skin rash	☐Feeling in dream-like state	☐Difficulty swallowing	☐_____
☐Aggressive/violent behavior	☐Isolation/withdrawal	☐Nausea	☐_____

List your favorite activities: _____
List your interpersonal and other assets (not financial): _____
_____