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
- ☐ Navy
- ☐ Air Force
- ☐ Marines
- ☐ Coast Guard

Served from ______ to _______
Rank: _______________
Type of Discharge: ___________
Specialty/MOS: ______________

Legal History

Have you been convicted of a misdemeanor or felony? ☐ Yes ☐ No

If yes, provide details of all convictions: ______________________________________

____

Religious Affiliation

REASON FOR APPOINTMENT (Please check all that apply)

- ☐ Alcohol
- ☐ Anxiety
- ☐ Behavior Problem
- ☐ Bipolar
- ☐ Depression
- ☐ Drugs
- ☐ Eating Disorder
- ☐ Family Issues
- ☐ Legal Issues
- ☐ Manic
- ☐ Marital/Sexual Issues
- ☐ Panic Attack
- ☐ Physical Abuse
- ☐ Problem at Work
- ☐ School Problems
- ☐ Sexual Abuse
- ☐ Stress
- ☐ Suicidal Thoughts
- ☐ Other ________________________

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.			

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 any drug allergies: ____

Current medications (specify type)

- ☐ Anxiety_________________
- ☐ Aspirin
- ☐ Birth Control
- ☐ Blood Pressure__________
- ☐ Cold/Allergy___________
- ☐ Cortisone
- ☐ Decongestant___________
- ☐ Depression_______________
- ☐ Diet ____________________
- ☐ Diuretic________________
- ☐ Hormones______________
- ☐ Laxatives_______________
- ☐ Nasal spray_____________
- ☐ Pain pills_______________
- ☐ Sleeping Pills _____________
- ☐ Tranquilizer______________
- ☐ Vitamins________________
- ☐ ________________________
- ☐ ________________________
- ☐ ________________________
- ☐ ________________________

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
☐Weakness
☐Lack of sleep
☐Sleeping too much
☐Increase/decrease in appetite
☐Increase/decrease in weight
☐Repetitive/senseless thoughts
☐Repetitive/senseless behavior
☐Sad/down in the dumps
☐Depressed
☐Irritability/anger
☐Nervousness
☐Fearful feelings
☐Frequent crying
☐Frequent negative thinking
☐Frequent thoughts of death
☐Suicidal thoughts
☐Homicidal thoughts
☐Fainting, feeling faint
☐Tremors
☐Trembling or shakiness
☐Seizures/convulsions
☐Skin rash
☐Aggressive/violent behavior

☐Seeing things that are not real
☐Hearing things that are not real
☐Difficulty making decisions
☐Difficulty concentrating
☐Memory problems
☐Worthless feelings
☐Excessive guilt feelings
☐Hopeless feelings
☐Helpless feelings
☐Sweating
☐Dizziness/light headedness
☐Unsteady feelings
☐Jumpiness
☐Keyed up/on edge
☐Restlessness
☐Constant worry
☐Panic
☐Feeling life not worth living
☐Increase/decrease in sex drive
☐Fear of going crazy
☐Fear of dying
☐Feelings of unreality
☐Feeling in dream-like state
☐Isolation/withdrawal

☐Double vision
☐Difficulty in focusing vision
☐Eye pain
☐Eye discomfort in bright light
☐Sinus pain or congestion
☐Increase/decrease in tearing
☐Increased sensitivity to sounds
☐Ear Infections
☐Joint pain or stiffness
☐Backache
☐Muscle tension
☐Muscle pain/soreness
☐Swelling of hands/feet/ankles
☐Leg cramps
☐Numbness/tingling in limbs
☐Foot problems
☐Trouble walking
☐Balance problems
☐Cold/clammy hands
☐Unable to sit still
☐Chest pain/discomfort
☐Palpitations
☐Difficulty swallowing
☐Nausea

☐Diarrhea
☐Constipation
☐Indigestion/heartburn
☐Vomiting
☐Rectal bleeding
☐Black, tarry stools
☐Food Intolerance
☐Inability to control bowels
☐Fear of losing bowel control
☐Hay fever, allergies
☐Cough/ coughing up blood
☐Wheezing
☐Shortness of breath
☐Dry mouth
☐Unusual taste sensations
☐Frequent/painful urination
☐Inability to control urine
☐Penile/vaginal discharge
☐Penile/vaginal sores
☐Difficulty in sexual function
☐Breast discharge
☐______________________
☐______________________
☐______________________

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