DEBORAH S. LYONS Ph.D.

4310 Medical Parkway, Suite 103 Austin, TX 78756
512.459.1272 • dlyonsphd@gmail.com
www.deborahslyonsphd.com

Today's Date: _____

ADULT PATIENT HISTORY FORM

Last Name:		**First Name:**	
Gender:	**DOB:**	**Age:**	**Race:**
Referred By:			

Relationship status

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Cohabitating ☐Partnered
Spouse/Partner's name:
Previous marriages: ☐ YES ☐NO If Yes, please provide those dates:

Children

1.Name	Age	☐ Living ☐Deceased
☐Biological ☐Stepchild ☐Adopted	Currently Lives With:	

2.Name	Age	☐ Living ☐Deceased
☐Biological ☐Stepchild ☐Adopted	Currently Lives With:	

3.Name	Age	☐ Living ☐Deceased
☐Biological ☐Stepchild ☐Adopted	Currently Lives With:	

4.Name	Age	☐ Living ☐Deceased
☐Biological ☐Stepchild ☐Adopted	Currently Lives With:	

1. IDENTIFYING COMPLAINT:

Please identify the reason you are seeking treatment:

When did the problem(s) begin and what motivated you to seek treatment now?

List anything you did to improve the problem:

Please estimate the current level of severity of the problem, using the following scale (Circle One):

Mildly Upsetting	Moderately Severe	Very Severe	Totally Incapacitating

2. EDUCATIONAL/EMPLOYMENT HISTORY:

Highest Grade/Degree Completed: _____ **Year of Completion:** _____

Did you have any difficulties in school? ☐YES ☐NO (If yes, please explain)

If you are currently a student, where do you attend school?

Current employment:

Job Title:_____ **☐Full Time ☐Part Time**

Employer:_____ **Length of Employment:**_____

Partner/Spouse:

Job Title:_____ **☐Full Time ☐Part Time**

Employer:_____ **Length of Employment:**_____

DOB:_____

Briefly describe your previous jobs:

3. MEDICAL HISTORY:

Do you have any major medical illnesses, previous hospitalizations, or accidents? Please list:

List all past and present mental health treatment:

Dates	Type of Treatment	Provider's Name	Location

Have you ever been hospitalized for psychiatric reasons? If yes, where/when:

List all current medications, their dosage and the prescribing doctor:

List all medications taken in the past for emotional/psychiatric reasons (including difficulty sleeping) and dates used:

Are you allergic to any medication or substances? Please list

____

____

____

Have any of the following conditions ever applied to you? (Check all that apply):

☐Liver Disease ☐Kidney Disease ☐Pancreatic Disease
☐Cancer ☐Heart Trouble ☐Diabetes
☐Epilepsy ☐Thyroid Disease ☐Mononucleosis
☐School Phobia ☐Truancy ☐Family Problems
☐Childhood Fears ☐Running Away ☐Behavior Problems
☐Hyperactivity ☐Attention Deficit ☐Bedwetting
☐STDs ☐HIV/AIDS ☐Infertility
☐Teenage Pregnancy ☐Sexual Abuse ☐Incest
☐Sexual Problem ☐Anorexia ☐Binge Eating
☐Adoption ☐Menopause ☐Sexual Identity Issues
☐Physical Abuse ☐Domestic Violence ☐Rape
☐Divorce ☐Legal Problems ☐Financial Problems
☐Drug/Alcohol Addiction
☐Other:____

What recreational substances or drugs do you use/have you used, including alcohol and tobacco?

____

____

____

4. FAMILY BACKGROUND & MEDICAL HISTORY:

Please provide me with information for all biological, step, and adopted members of your family of origin:

Name________________Occupation______________________ AGE__________☐Living ☐Deceased
Role _______________☐Bio ☐Step☐Adopted Highest level education: ☐HS☐BS☐MS☐PhD☐JD☐MD

Name________________Occupation______________________ AGE__________☐Living ☐Deceased
Role _______________☐Bio ☐Step☐Adopted Highest level education: ☐HS☐BS☐MS☐PhD☐JD☐MD

Name________________Occupation______________________ AGE__________☐Living ☐Deceased
Role _______________☐Bio ☐Step☐Adopted Highest level education: ☐HS☐BS☐MS☐PhD☐JD☐MD

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Name________________Occupation______________________ AGE__________☐Living ☐Deceased
Role _______________☐Bio ☐Step☐Adopted Highest level education: ☐HS☐BS☐MS☐PhD☐JD☐MD

Are/were your parents (Check all that apply)
☐Never Married ☐Married ☐Divorced ☐Remarried ☐Widowed

How old were you when they were divorced/remarried/widowed? _____

If they divorced while you were still a minor, with whom did you live? _____

Amongst your *children, siblings, parents, or grandparents,* please list any past or currently significant:

A. Medical problems:

B. Mental illnesses: (e.g. depression, anxiety, chemical dependency, psychiatric hospitalizations, abuse, ADHD)

C. Learning difficulties:

D. Legal problems:

E. Financial problems:

5. IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW ABOUT YOU?