

**Adult Information Form**

Client Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ OK to leave message? \_\_\_Yes \_\_\_No  
Work Phone: ( ) \_\_\_\_\_ OK to leave message? \_\_\_Yes \_\_\_No  
Current Employer (or school if a student): \_\_\_\_\_  
Gender: \_\_\_Male \_\_\_Female Who referred you here? \_\_\_\_\_

**WHO MAY WE CONTACT IN CASE OF EMERGENCY?**

Daytime Phone: ( ) \_\_\_\_\_ Evening Phone: ( ) \_\_\_\_\_  
Spouse's Name (if applicable): \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

**Current Marital Status**

\_\_\_ Single (duration: \_\_\_\_\_) \_\_\_ Married (duration: \_\_\_\_\_)  
\_\_\_ Cohabiting (duration: \_\_\_\_\_) \_\_\_ Separated (duration: \_\_\_\_\_)  
\_\_\_ Divorced (duration: \_\_\_\_\_) \_\_\_ Widowed (duration: \_\_\_\_\_)

**Education**

Currently in school: \_\_\_Yes \_\_\_No Total years of education: \_\_\_\_\_  
\_\_\_ High School Graduate  
\_\_\_ G.E.D. Major area(s) of study/training  
\_\_\_ Vocational: # of years \_\_\_\_\_ Graduated: \_\_\_Yes \_\_\_No \_\_\_\_\_  
\_\_\_ College: # of years \_\_\_\_\_ Graduated: \_\_\_Yes \_\_\_No \_\_\_\_\_  
\_\_\_ Grad. School: # of years \_\_\_\_\_ Graduated: \_\_\_Yes \_\_\_No \_\_\_\_\_  
Special Services? (Special education, learning disabilities, etc) \_\_\_\_\_

**Employment**

Are you currently employed? \_\_\_Yes \_\_\_No  
Current Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_  
Length of time employed: \_\_\_\_\_ Job responsibilities: \_\_\_\_\_  
Level of stress of job: \_\_\_\_\_ Other jobs you have worked: \_\_\_\_\_

**Legal**

Are you involved in any legal activities (civil, criminal, custody, probation/parole, etc.)? \_\_\_Yes \_\_\_No  
If yes, please describe:  
Past History:  
Traffic violations: \_\_\_Yes \_\_\_No DUII/DWI, etc: \_\_\_Yes \_\_\_No  
Felony/Misdemeanor charges? \_\_\_Yes \_\_\_No Civil/custody lawsuits: \_\_\_Yes \_\_\_No

**Military Experience**

Military experience? \_\_\_Yes \_\_\_No (If no, skip this section)  
Branch of Service: \_\_\_\_\_ Date enlisted/drafted: \_\_\_\_\_  
Discharge date: \_\_\_\_\_ Type of discharge: \_\_\_\_\_ Rank at discharge: \_\_\_\_\_  
Combat experience? \_\_\_Yes \_\_\_No Other stressors experienced: \_\_\_\_\_

**Therapist Notes:**

# Adult Information Form

## PRESENTING PROBLEMS/CONCERNS

Describe the problem that brought you here today:

What do you hope to gain from therapy:

Please check behaviors and symptoms that occur to you more often than you would like:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Aggression/fighting | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Sleeping problems     |
| <input type="checkbox"/> Alcohol abuse       | <input type="checkbox"/> Drug abuse          | <input type="checkbox"/> Judgment errors     | <input type="checkbox"/> Speech problems       |
| <input type="checkbox"/> Angry outbursts     | <input type="checkbox"/> Eating disorder     | <input type="checkbox"/> Loneliness          | <input type="checkbox"/> Suicidal thoughts     |
| <input type="checkbox"/> Arguments/conflicts | <input type="checkbox"/> Elevated mood       | <input type="checkbox"/> Memory impairment   | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Mood swings         | <input type="checkbox"/> Trembling             |
| <input type="checkbox"/> Avoiding people     | <input type="checkbox"/> Gambling            | <input type="checkbox"/> Panic attacks       | <input type="checkbox"/> Withdrawing           |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Hallucinations      | <input type="checkbox"/> Phobias/fears       | <input type="checkbox"/> Worrying              |
| <input type="checkbox"/> Computer addiction  | <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Recurring thoughts  | <input type="checkbox"/> Other (specify):      |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sexual addiction    |  |
| <input type="checkbox"/> Disorientation      | <input type="checkbox"/> Hopelessness        | <input type="checkbox"/> Sexual difficulties |  |
| <input type="checkbox"/> Distractibility     | <input type="checkbox"/> Impulsivity         | <input type="checkbox"/> Frequent illness    |  |

Briefly describe how the above checked symptoms impair your ability to function effectively:

Have you ever had thoughts or made statements of wanting to hurt yourself or seriously hurt someone else?  Yes  No. If Yes, please describe the situation:

Have you ever purposely hurt yourself or another?  Yes  No. If Yes, please describe situation:

## PRIOR MENTAL HEALTH TREATMENT

Type of Treatment	No	Yes	Start/End dates	Provider name/primary reason for treatment
Counseling or Psychiatric Care				
Drug/Alcohol Treatment				
Medication for mental health problem				
Self-help/support group				

**Therapist Notes:**

**FAMILY & DEVELOPMENTAL HISTORY**

Relationship	Name	Age	Deceased Y - N	Quality of Relationship	Family mental health problems?	Who?
Mother					Depression	
Father					Anxiety	
Stepmother					Sexual abuse	
Stepfather					Attention deficit	
Spouse/partner					Alcohol abuse	
Children					Drug abuse	
					Schizophrenia	
					Manic-depression	
					Imprisonment	
Siblings					Suicide	
					Eating disorders	
					Panic attacks	
					Obsessive/ compulsive	

**Parental Marital Information:**

- Parents legally married
- Parents have been separated
- Parents divorced
- Mother remarried: Number of times
- Father remarried: Number of times

Is there anything happening NOW in your current living situation or in your family that is especially stressful for you?

Please check if you have suffered any of the following types of trauma:

- Neglect
- Sexual abuse
- Teenage pregnancy
- Violence in the home
- Parental illness
- Multiple family moves
- Emotional abuse
- Loss of a loved one
- Parental substance abuse
- Parents separated or divorced
- Homelessness
- Other
- Physical abuse
- Natural disaster
- Crime victim
- Financial problems
- Lived in a foster home

Please comment on any of the above checked items (including your age when the trauma occurred and the details of the traumatic event):

**Therapist Notes:**

**CHEMICAL USE HISTORY**

Substance Type	Current Use (within the last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
PCP/LSD								
Heroin/opiates								
Methamphetamines								
Inhalants								
Other								

Have you had withdrawal symptoms when trying to stop using any substances?  Yes  No. If yes, please describe the situation:

Have any substances created a problem for you at work or home?  Yes  No. If yes, please describe the situation:

**Therapist Notes:**

**SOCIAL/CULTURAL HISTORY**

Please check how you generally get along with other people: (check all that apply)

- Affectionate     Aggressive     Assertive     Avoidant     Follower  
 Fight/argue often     Leader     Outgoing     Shy/withdrawn     Submissive

Describe special areas of interest or hobbies (i.e., art, books, crafts, physical fitness, etc.)

Activity	How often now?	How often in the past?

Please describe your strengths, skills and talents:

To which cultural or ethnic group do you belong?

Are you experiencing any difficulties due to cultural or ethnic issues? If yes, please describe:

How important are spiritual matters to you? \_\_\_ Not at all \_\_\_ Little \_\_\_ Somewhat \_\_\_ Very much

Are you affiliated with a particular spiritual or religious group? \_\_\_ Yes \_\_\_ No. If yes, please describe:

Would you like your spiritual/religious beliefs incorporated into the counseling? \_\_\_ Yes \_\_\_ No

**MEDICAL INFORMATION**

Current Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

When was your most recent complete physical examination? \_\_\_\_\_

Have you suffered from any of the following medical conditions during your lifetime?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> A serious accident | <input type="checkbox"/> Surgery             | <input type="checkbox"/> Allergies                      |
| <input type="checkbox"/> A head injury      | <input type="checkbox"/> Meningitis          | <input type="checkbox"/> Hospitalizations               |
| <input type="checkbox"/> High fevers        | <input type="checkbox"/> Hearing problems    | <input type="checkbox"/> Headaches                      |
| <input type="checkbox"/> Vision problems    | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Loss of consciousness          |
| <input type="checkbox"/> Ear infections     | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pregnancy/miscarriage          |
| <input type="checkbox"/> Stomach aches      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Speech/language problems       |
| <input type="checkbox"/> Abortion           | <input type="checkbox"/> Chronic pain        | <input type="checkbox"/> A sexually transmitted disease |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Thyroid problems               |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Other _____         | <input type="checkbox"/> Other _____                    |

Please describe any checked items, noting your age at the time of onset:

List any current health concerns:

Current medications: \_\_\_ None

<u>Medication</u>	<u>Dosage</u>	<u>Date First Prescribed</u>	<u>Prescribed By</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter medications: (please include vitamins, herbal remedies, etc.)

Allergies and/or adverse reactions to medications:

<b>Therapist Notes:</b>   
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