Adult Information Form

Client Name: ______________________________ Age: _______ DOB: ___________ Date: ________

Gender: _______________________ Ethnicity: ________________________________

Address: ____

City: ________________ State: _____ Zip: ______

Mobile Phone: ( )______________________ OK to leave message? ___ Yes ___ No

Home Phone: ( )______________________ OK to leave message? ___ Yes ___ No

Work Phone: ( )______________________ OK to leave message? ___ Yes ___ No

Email: __________________________________ OK to use? (see informed consent) ___ Yes ___ No

Who referred you here? ____

Current Employer (and/or school if a student): _______________________________________

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 Legal 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:

PRESENTING PROBLEMS/CONCERNS

Describe the problem(s) that brings you to treatment:

What do you hope to gain from therapy?

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

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

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Briefly describe how the previous 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				

Have you ever been diagnosed with a mental disorder? ___ Yes ___ No. If Yes, please indicate with what disorder(s) you were diagnosed, when you were first diagnosed, and who made the diagnosis.

FAMILY & DEVELOPMENTAL HISTORY

Relationship	Name	Age	Deceased Y/N	Quality of Relationship
Spouse/partner?				
Children?				
Mother				
Father				
Stepmother?				
Stepfather?				
Siblings?				

What is your current living situation?
___ Rent ___ Own ___ Other (please explain):

Who else resides in the home with you?

Family mental health problems?	Who?	Family mental health problems?	Who?
Depression		Bipolar	
Anxiety		Imprisonment	
Sexual abuse		Suicide	
Attention deficit		Eating disorders	
Alcohol abuse		Panic attacks	
Drug abuse		Obsessive/ compulsive	
Schizophrenia		Other:	

Parental Marital Information:

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

Describe the quality of your upbringing and of your childhood household environment:

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):

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								
Marijauna								
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:

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 your level of satisfaction with your current relationships (quality and quantity of friendships, frequency of contact with others):

___ (1) Very dissatisfied
___ (2) Somewhat dissatisfied
___ (3) Neither satisfied nor dissatisfied
___ (4) Somewhat satisfied
___ (5) Very satisfied

Describe:

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. If yes, how?

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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?

___ A serious accident	___ Surgery	___ Allergies
___ A head injury	___ Meningitis	___ Hospitalizations
___ High fevers	___ Hearing problems	___ Headaches
___ Vision problems	___ Asthma	___ Pregnancy/miscarriage
___ Ear infections	___ High blood pressure	___ Speech/language problems
___ Stomach aches	___ Diabetes	___ A sexually transmitted disease
___ Abortion	___ Chronic pain	___ Thyroid problems
___ Cancer	___ Heart problems	___ Other:
___ Seizures	___ Loss of consciousness	

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

List any other current health concerns:

Current medications: ___ None

Medication	**Dosage**	**Date First Prescribed**	**Prescribed By**
___________________	_________	___________________	________________________
___________________	_________	___________________	________________________
___________________	_________	___________________	________________________
___________________	_________	___________________	________________________

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

Allergies and/or adverse reactions to medications:

Therapist Notes

THIS PAGE FOR OFFICE USE ONLY			
Client Name	**Date**	**Duration (mins)**	**Location**
		53	Office
Others in session	**Pr. Code**	**Session #**	
None	90791	1	

Mental Status:

Clinical Summary:

Diagnostic Impressions:

Treatment Plan:

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