

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:

- | | |
|--|--|
| <input type="checkbox"/> Parents legally married | <input type="checkbox"/> Mother remarried: Number of times |
| <input type="checkbox"/> Parents have been separated | <input type="checkbox"/> Father remarried: Number of times |
| <input type="checkbox"/> Parents divorced | |

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:

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

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:

Therapist Notes:
