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Adult Information Form

Name ____

Date of Birth ____________________ Gender: Male Female Other ____________________

Date of First Appointment ____________________ Today's Date ____________________

Medical History

Name of Primary Care Physician ____

Physician's Address ____

Physician's Phone ____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor?

◯ Yes ◯ No Signature (required) ____

Date of last medical evaluation ____________________ Date of next appointment ____________________

List any medications you have been prescribed.

Name of medication	Dosage	Date started	Purpose	Prescriber

List any recreational drugs you use.

Name of drug	Date started	How much	How often

Examples of recreational drugs include

- *alcohol,*
- *tobacco,*
- *marijuana,*

or any drug you use for fun that has not been prescribed to you by a physician.

Have you ever been hospitalized for medical or psychiatric reasons? ◯ Yes ◯ No

Reason for hospitalization ____ Date____________

Describe any important medical history, chronic ailments, or other health problems you experience.

____
____
____
____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments.

____
____
____
____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? ◯ Yes ◯ No

____
____
____
____

School, Work and Family History

School History

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? ◯ Yes ◯ No

____
____

What is highest level of education you completed? ________________________________

If you did not complete high school, please explain. ______________________________

Family History

How would you describe your current support network? (friends, relatives, etc.)

____
____
____

Do you have siblings? If so, list them.

Name	Relation	Age	Sex

Please check all information which applies to your biological parents

Mother: ☐ living ☐ deceased ☐ married ☐ divorced ☐ remarried

Father: ☐ living ☐ deceased ☐ married ☐ divorced ☐ remarried

Do you consider someone else to be one or both of your "real" parents? ◯ Yes ◯ No

Who? ______________________________

Where do your parents live? ______________________________

Describe your relationship with your parents, both currently and while growing up.

____

____

Describe any family problems which occurred while growing up relating to drug, sexual, physical, or emotional abuse.

____

____

____

Marital History

Marital status: ◯ never married ◯ married ◯ separated ◯ divorced ◯ widowed ◯ cohabiting

If you are married or in a relationship, when did it begin? ______________________________

Describe your relationship. ______________________________

____

Do you have children? If so, list them.

Name	Age	Relationship (biological, step-child, etc.)	Lives with whom?

Mental Status

How have you been feeling lately? Check any of the following that describe your emotional state.

☐ sad	☐ angry	☐ tearful	☐ hopeless
☐ anxious	☐ ashamed	☐ irritable	☐ helpless
☐ depressed	☐ aggressive	☐ confused	Other: __________
☐ frightened	☐ resentful	☐ extreme ups & downs	__________
☐ guilty	☐ worthless	☐ jealous	__________

What activities or hobbies do you participate in? ______________________________

____

Do you participate in regular exercise? ◯ Yes ◯ No Describe. ______________________________

Describe your current work environment. ______________________________

Have you had any change in sleeping habits? ○ Yes ○ No Describe. ______________________________

Have you had any change in eating habits? ○ Yes ○ No Describe. ______________________________

Have you ever considered suicide in connection to your current problem? ○ Yes ○ No

Describe, including dates. ______________________________

Have you ever considered suicide in the past? ○ Yes ○ No Describe, including dates. ______________________________

Have you attempted suicide recently or in the past? ○ Yes ○ No Describe, including dates. ______________________________

Have you had any homicidal thoughts recently or in regard to your current problem? ○ Yes ○ No

Describe, including dates. ______________________________

Have you ever considered homicide in the past? ○ Yes ○ No Describe, including dates. ______________________________

Level Of Functioning

Describe any current impediments or problems in daily psychological, social or occupational functioning, i.e. isolation from friends or family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, or problems with a supervisor.

____

Thoughts

Please check any of the following that apply to you:

- ☐ I sometimes hear voices even though no one nearby is talking to me.
- ☐ I sometimes feel that forces outside of me control me.
- ☐ I sometimes feel that other people control my thoughts.
- ☐ I sometimes have the same thought over and over and cannot control it.
- ☐ I sometimes feel that someone is out to hurt me or do something against me.
- ☐ I am sometimes unable to control my behavior.

What are your therapy goals?

Is there any other information regarding you or your family that you would like to share with your therapist that is not covered on this form? You may also use this space to complete earlier responses.