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Adult Information and History

Todays Date: ___________________

Personal Information

Name _________________________________

Home Address ____

City/State/Zip ____

Home and Cell Phone ____

Work Phone __________________________

Drivers License # _______________________

Date of Birth ___________________________

Social Security Number _________________

Marital Status _________________________

Occupation ____________________________

Employer /School_______________________

Work Address ____

City/State/Zip ____

Work Phone ____

Name of Spouse/Partner ____

May we call you …at home? yes no …at work? yes no

Person completing form (if other than patient):____________________________

Relationship:___________________________

Name of Guardian (if applicable): _________________________________

Emergency Information
Contact person in case of emergency: ___________________Relationship:___________________

Phone #:_____________________________

Physician Information
Primary Care Physician______________________________________

Phone Number________________________________

Referred By ___________________________________

REASON FOR VISIT

Please describe your PRIMARY reasons for seeking therapy/counseling (include year/month the difficulties started):

Was there a significant event which made these issues or problems surface? Yes No
If yes, describe:

What motivated you to get help now?

Patient Name____________________________

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:
(Place an X in the appropriate box)

	No Effect	Little Effect	Some Effect	Much Effect	Significant effect	Not Applicable
Marriage						
Family						
Job or School Performance						
Friendships						
Hobbies						
Financial Situation						
Physical Health						
Anxiety level						
Mood						
Eating habits						
Sleeping habits						
Sexual functioning						
Ability to concentrate						
Ability to control your temper						

Please answer whether or not you are <u>CURRENTLY</u> experiencing any of the following symptoms:

Suicidal Thoughts/Impulses .... N____ Y____

Homicidal Thoughts/Impulses .... N____ Y____

Appetite Problems .... N____ Y____

Sleep Problems .... N____ Y____

Physical Complaints .... N____ Y____

Anger/Irritability .... N____ Y____

Isolation/Social Withdrawal .... N____ Y____

Anxiety/Panic .... N____ Y____

Phobia .... N____ Y____

Bingeing/Purging .... N____ Y____

Poor Impulse Control .... N____ Y____

Violence Toward Others .... N____ Y____

Destruction of Property .... N____ Y____

Strange or Unusual Behavior .... N____ Y____

Confused or Irrational Thinking .... N____ Y____

Bothersome Repetitive Thoughts or Behaviors N____ Y____

Self-mutilation .... N____ Y____

Psychiatric History

Have you received any Psychological/Psychiatric treatment before? No___ Yes___

What was your age at the first visit? _____

If you checked Yes to the above question, please answer the following for the most RECENT TREATMENTS:

What type of care did you receive? Inpatient (hospital) Outpatient Both

When were you in treatment?____

Where were you in treatment? ____

How long were you in treatment? ____

Who was your therapist and psychiatrist?

____

Did your psychiatrist prescribe medicine at this time? Yes No Not applicable

If yes, what was prescribed (include dosages if known) ?

Substance Use History

How much alcohol do you drink per week on average? _____ drinks per week

How much alcohol did you drink per week on average for the last 5 years? ______ drinks per week

Have you had problems with your drinking (legal, health, work, relationship?)

No___ Yes___ If Yes, please explain:

____

____

Have you had any inpatient/hospital treatment for mental health or substance abuse?

No___ Yes___

[If Yes, please list facility(ies) date(s) and length(s) of stay(s)]:

____

____

Did you or do you use any illicit drugs? Yes No

Please list:

PAST	PRESENT
________________________	________________________
________________________	________________________
________________________	________________________

Please describe the alcohol and/or drug use for your PAST and PRESENT USE:

Substances When? (first use, last use)	Amount	Frequency
______________________________	________	_______________
______________________________	________	_______________
______________________________	________	_______________

Do you have a history of blackouts, seizures, or withdrawal symptoms? Yes No

Habits:	Amount Currently Using	Most Ever Used
Coffee (cups/day)	____________________	______________
Cigarettes (packs/day)	____________________	______________

Alcohol ______________________ ________________

Medical History

Current Medical Condition(s):

____

____

Please list any prescription medications you currently use:

NAME	DOSAGE	FREQUENCY

Please list any over-the-counter medications you CURRENTLY use:

NAME and DATE BEGAN	DOSAGE	FREQUENCY

Please list any past or present MEDICAL conditions that you have been treated for:

____

____

____

Have you ever had a brain injury or a neuropsychological exam? Yes No
Please describe:

When did you last have a physical examination?

____

Patient Name_________________________________

Whom did you see? ____
Name Phone Number

Do you have any allergies? No___ Yes___ If yes, please list:
____

____

____

Family History

How many siblings did you have? Full ________ Half ________ Step ________

How many times was your mother married? ______________

How many times was your father married? _______________

Describe any significant conditions of your parents and/or other family members, and please list relationship to family member:

Emotional:

Medical:

Chemical dependency:

Developmental History

Did you experience any type of developmental delays as a child? Please describe:

Did you experience any type of learning difficulty or academic difficulty as a child? Please describe:

Goals

Please list your primary goals for treatment in order (begin with the most important):