

**Aspiring Families, Center for the Child and Family**  
**Emily Merryweather, M.A., NCC, LPCC**  
**(LPCC # 4676)**  
**12625 High Bluff Drive, Suite 104**  
**Tel: (760)783-5583, Fax: (877) 720-9488**  
**emerryweather@sandiego.edu**

**Adult Information and History**

---

**Today's 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**

Patient Name \_\_\_\_\_

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?

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						

Patient Name \_\_\_\_\_

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 CURRENTLY 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\_\_\_

Patient Name \_\_\_\_\_

## 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

Patient Name \_\_\_\_\_

Please list:

PAST

PRESENT

---

---

---

---

---

---

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

<u>Substances</u> <u>When? (first use, last use)</u>	<u>Amount</u>	<u>Frequency</u>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

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

<u>Habits:</u>	<u>Amount Currently Using</u>	<u>Most Ever Used</u>
Coffee (cups/day)	<hr/>	<hr/>
Cigarettes (packs/day)	<hr/>	<hr/>
Alcohol	<hr/>	<hr/>

**Medical History**

Current Medical Condition(s):

---

---

Please list any prescription medications you currently use:

<u>NAME</u>	<u>DOSAGE</u>	<u>FREQUENCY</u>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>



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):