ADULT INFORMATION FORM

Name_________________________________ Date: _________________ Date of Birth:_______________

MEDICAL & PSYCHIATRIC HISTORY

Name of Primary Care Physician: ______________________________________ Physicians Phone: ________________

Physician's Address:____

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? (Circle One) YES NO

Please sign here for either answer:____

Date of last medical evaluation:___________________ Date of next appointment:__________________________

Have you been diagnosed with any type of medical condition? ____

____

Current medications being taken:

1)_______________________ Dosage/Freq___________ Start Date___________Purpose_________________________

2)_______________________ Dosage/Freq __________ Start Date___________ Purpose_________________________

3)_______________________ Dosage/Freq __________ Start Date___________Purpose_________________________

4)_______________________ Dosage/Freq __________ Start Date___________Purpose_________________________

Prescribed by: ____

Do you take your medications as prescribed (Circle one) YES NO Reason____________________________________

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
____________________________________	_______	____
____________________________________	_______	____
____________________________________	_______	____

Prior Outpatient Therapists/Treatment	Mo/Yr	Reason
____________________________________	_______	____
____________________________________	_______	____
____________________________________	_______	____
____________________________________	_______	____

Current Stress: Explain what the stress is and how it impacts your quality of life.

1. Housing ____

2. Finances ____

3. Legal Problems____

4. Job/School____

5. Relationships____

6. Other____

Do you use recreational drugs? (Circle One) YES NO

If no, have you used previously? (Circle One) YES NO If yes, when did you stop? ______________________

Type of Drug	How much	How often

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often

Have you ever felt the need to cut down on your drinking? (Circle One) YES NO

Have people annoyed you by criticizing how much you drink? (Circle One) YES NO

Have you ever felt guilty about drinking? (Circle One) YES NO

Have you ever felt the need to drink first thing in the morning to steady your nerves and get rid of a hangover? (Circle One) YES NO If yes, how often? ________________ Do you drink along or with others (Circle)

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind?

____

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

____

____

Do you exercise regularly? (Circle One) YES NO ____

Do you eat balanced meals regularly (Circle One) YES NO If no, please explain__________________________

____

How do you cope with stress? What do you do to help calm yourself down? ___________________________

____

What works to help calm you down? What does not work to help calm you down? ______________________

____

____

Who do you seek out for support when you are in distress? _______________________________________

What do you think you need to better take care of yourself?_______________________________________

____

FAMILY MEDICAL HISTORY

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? Please list:

____

____

____

SCHOOL HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain:____

____

____

What was the last year of school you completed? ____________ If you did not complete high school, please explain: ____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)_______________________________ Year(s)____________________

(2) School(s)_______________________________ Year(s)____________________

(3) School(s)_______________________________ Year(s)____________________

Who were your friends growing up?______________________ How do you know?__________________

Growing up, what type of class were you in: ☐Regular ☐Gifted ☐Resource ☐SED

Did you have any academic or learning problems ____

Did you experience bullying? (Circle One) YES NO If yes, how and when_______________________________

____

How was the bullying handled by adults? ____

Any discipline problems____

Suspensions/expulsions____

Repeated grades____

Skipped grades____

What caused distress for you?____

What is your preferred style of learning: ☐Visual ☐ Auditory ☐Kinesthetic

Any special learning needs: ____

____

FAMILY and SUPPORT HISTORY

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

____

____

Please check all information which applies to your biological parents:

MOTHER
____ living
____ deceased
____ married
____ divorced
____ remarried ____# of times

FATHER
____ living
____ deceased
____ married
____ divorced
____ remarried ____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? Whom?

____

Where do your parents live? Mother ____

Father ____

Describe your relationship with your mother while growing up____________________________

____

____

Currently:____

____

____

Describe your relationship with your father while growing up: ____________________________

____

____

Currently:____

____

____

How were you disciplined growing up? ____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)

Describe any family problems which occurred while growing up related to:

Alcohol/Drug Abuse: ____

____

____

Sexual/Phsyical/Emotional Abuse: ____

____

____

____

MARITAL HISTORY

Marital status: ___Single ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? ______________________________

If divorced, when were you divorced? Why? ______________________________

If living w/someone, who/how long? ______________________________

Please list your children:

Name	Age	Relationship (biological/step)	Lives with

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ___resentful
____worthless ___tearful ____irritable ____helpless _____extreme ups/downs _____jealous _____hopeless

Describe any other feelings you have had:______________________________

____

What activities or hobbies do you participate in? ______________________________

____

Describe your current working environment:______________________________

____

Have you had any change in sleeping habits? (Circle One) YES NO Describe:______________________________

____

How many hours do you typically sleep a night?________ Do you have problems staying or falling asleep? ________

How often do you sleep throughout the day? ____________________ How come?______________________________

Have you had any change in eating habits? (Circle One) YES NO Describe: ______________________________

____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:______________________________

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:______________________________

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:______________________________

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain:______________________________

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain:______________________________

What gives you reasons to live?______________________________

____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): ____

____

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. Please explain:____

____

____

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.

____

____

____

____

____

Please list your therapy goals:

____

____

____

____

____

Please list your expectations for treatment:

____

____

____

____

THANK YOU!