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

Robyn Coughlin, LCSW