Crites Counseling & Consultation

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Adult Information Form

IDENTIFICATION Today's Date: _____

Your name: _____ Date of birth: _____

Calls or e-mail will be discreet, but please indicate any restrictions: ___None

REFERRALL: HOW DID YOU FIND OUT ABOUT THIS PRACTICE?

How did you find out about CPC? ___Yellow Pages (_____) ___Your Insurance Company Web site or Listing

___Church:_____ ___Friend/Associate:_____

___General Web Search ____Crites Counseling & Consultation Website ___Coppell Counseling Website

___Physician/Counselor:_____

___Other:_____

Please identify the friend, associate, agency, physician or other professional in the space provided below.

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

PHYSICAL

You were born after ___ months pregnancy, weighing _____. You were pregnancy number _____.

Pregnancy and Delivery: □ Normal □ Other_____ _____

Compared to other children in the family your development was: □ Slower □ About the same □ Faster

Comments

I am: □ Right handed □ Left handed □ Ambidextrous

MEDICAL CARE From whom or where do you get your medical care?

Clinic/doctor's name: _____Phone: _____

Address_____

If you enter treatment with me for psychological problems, may I talk to/share information with your medical doctor so that he/ she can be fully informed, and we can coordinate your treatment? ❑ Yes ❑ No Initial please_____

HEALTH INFORMATION HISTORY

Rate your Health: ___Very Good ___Good ___Average ___Poor Is it declining? ___No ___Yes If so how?

Your approximate weight: ____Lbs. Recent weight change (last three months): Lost _____lbs. Gained _____lbs.

If there was a recent weight change what do you think caused it?

Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had (pregnancies may be described in women's section).

Age __Illness/diagnosis ___ Treatment received _____Treated by _____Result_____

Describe any airborne or food allergies you have.

To what? _____ Reaction you have _____ Allergy medications you take _____

Pease list any over the counter or prescription medications you are currently taking and what you are taking them for:

Medication	**Given For**

Did you ever fall from a grocery cart, bed, changing table, etc., during infancy or early childhood? If yes, please explain what happened

Have you ever been in a motor vehicle/motorcycle accident? If yes, please explain what happened.

Have you ever lost consciousness after being hit in the head? If yes, please explain what happened.

Did you ever fall off a bike, skateboard, recreational vehicle, or fallen when playing (swing, trapeze bars, swimming, diving, etc.) and hurt your head? If yes, please explain what happened.

HEALTH HABITS

What kinds of physical exercise do you get and how often to you participate in it?

How much coffee, cola, tea, or other sources of caffeine do you consume each day? Which?

Do you try to restrict your eating in any way? How? Eating issues?

Why?

SLEEP: Do you have any problems getting enough sleep? ❑ No ❑ Yes. If yes, what problems?

How many hours do you sleep a night on average?

Are there ever times when you don't get sleep (less than 2-3 hours a night) and don't seem to be negatively affected the next day? ❑ No ❑ Yes. If yes, describe how you feel on those days!

If this happens, how often does it happen?

IF YOU ARE WORKING WHO IS YOUR CURRENT EMPLOYER

Employer: _____ Address: _____

Nature of Job:_____

EDUCATION AND TRAINING

Are you currently going to college/trade school? ___No ___Yes If yes, where?

Graduated from High School: ___No ___Yes If yes, when?

Graduated from College: ___No ___Yes If yes, when?

What degree(s) or certification(s) have you received?

MARRIAGE AND FAMILY INFORMATION

Have you been married? ___No ___Yes If yes, complete the following.

Name of spouse/partner_____ Date of Marriage:_____ Years Married:_____

Have you or your spouse/partner ever separated from the other? ___No ___Yes If so, when?_____

What was the reason and how was it resolved?

Have you ever had a divorce? ___No ___Yes If yes, when:_____

Is your spouse/partner willing to come to therapy if needed? ___Yes ___No If no, why not?

Do you have children? ___No ___Yes If yes, write down their names and ages below.

TOBACCO AND RECREATIONAL DRUGS

Do you use tobacco products? ❑ No ❑ Yes. If yes, how many cigarettes/cigars/other do you use each day?

Are you currently (within the last six months) using any drugs for recreational purposes? ___No ___Yes If yes please list the drug(s), frequency and amount.

Recreational Drug(s)	How Often	Amount	Last Time Used

Have you ever injected drugs? ❑ Yes ❑ No Ever shared needles? ❑ Yes ❑ No

Have you had HIV testing in the last 6 months? ❑ Yes ❑ No. If yes, results:

EMERGENCY INFORMATION

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call, with your permission?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____Phone:_____

RELIGIOUS AND RACIAL/ETHNIC IDENTIFICATION

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist

❑ Hindu ❑ No Religious Affiliation Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, etc. are you involved with?_____

Ethnicity/national origin: _____ Race: _____

EMOTIONAL/BEHAVORIAL

Mental Sense of Self

Do you exhibit thought distortions, e.g., all or nothing thinking, negative thinking, judgmental, jump to conclusions, over generalize, negative tapes? (___No ___Yes

If any of the above is a problem, how does it (they) contribute to any issues you are experiencing?

Social Sense of Self

Do you have ongoing weekly quality time with:

Your partner: ___Yes ___No Your family: ___Yes ___No Your friends: ___Yes ___No

Do you have alone time where you can take care of yourself and enjoy down time? ___Yes ___No

If any of the above is a problem, how does it (they) contribute to any issues you are experiencing?

Physical Sense of Self

Are you currently happy with: How you look physically: ___Yes ___No

How physically in shape you are: ___Yes ___No Your weight: ___Yes ___No

If any of the above is a problem, how does it (they) contribute to any issues you are experiencing?

Spiritual or Moral Sense of Self

Do you have a strong set of beliefs that you stand upon, that guides you when you make decisions? ___Yes ___No

If No, has a lack of spirituality or values contributed to any issues you are experiencing?

ADHD SECTION: Answer if you are wanting to be tested or treated for ADHD!

Did you have any characteristics of ADD/ADHD as a child/Elementary School? Put a check mark next to any characteristic that you believe you had in childhood.

____Difficult to get on task ____Easily Distractible ____Disorganized

____Impulsive words or actions ____Can't sit still/agitated ____Trouble Sustaining Attention

____Fails to finish chores/tasks ____Forgetful ____Fidgets with hands or feet

____Misplaces/can't find things ____Poor Follow-through ____On the go – Acts like Driven by a motor

Now go back to the items above. Circle ANY of the above that you believe you still have issues with today.

What kind of problems did the above characteristics cause you at school, home or socially when you were younger?

Describe how any of these characteristics are causing difficulties for you in your life right now.

SPECIFIC PROBLEM AREAS

Please check any of the following that are currently troubling you. This may be something you are personally troubled by, or something that someone who impacts you is experiencing.

___Abortion	___Eating Disorder	___Loss of Trust	___Suicidal Thoughts
___Abandonment Issues	___Envy/Jealousy	___Marriage Issues	___Self-esteem Issues
___ADHD/ADD	___Family Issues	___Medication/Drug Issues	___Trust Issues
___Adoption	___Family of Origin Issues	___Mid Life Crisis	___Violence/Rage
___Addictions	___Fear of Rejection	___Mother Issues	___Withdrawal
___Alcoholism	___Fear General	___Obsessive Thoughts	___Worry
___Anger Issues	___Finances/Debt	___Overwhelmed	___Other:
___Anxiety General	___Forgiveness	___Panic Attacks	
___Apathy	___Frustration	___Physical Abuse	
___Bipolar Disorder	___Gambling	___Pornography Use	
___Bitterness/Resentment	___Guilt/Shame	___PMS/Hormones	
___Burnout/Stress	___Health/Medical	___Religion/Faith Issues	
___Change of Life Style	___Honesty/Openness	___Rejection	___Other:
___Child Abuse	___Infidelity	___Romance	
___Children/Discipline	___In-laws	___Same Sex Attraction	
___Children/School	___Job Problems	___Self-Injury	
___Children Rebellion	___Legal Issues	___Separation	
___Codependency Issues	___Loneliness	___Sexual Abuse/Rape	
___Communication	___Loss of Appetite	___Sexual Addiction	
___Confusion	___Loss of Control	___Sexual Issues	
___Co-parenting Issues	___Loss of Concentration	___Sexual Enhancement	
___Crisis/Conflict	___Loss of Energy	___Single Parent	
___Death of loved one	___Loss of Memory	___Singleness	
___Depression	___Loss of Sleep	___Spouse Abuse	
___Divorce	___Loss of Temper	___Substance Abuse	

CONCLUSION: Fill out the following if you are coming in for therapy. If you are having testing done, you do not need to fill in the information requested below.

Pick the top three issues that are brought you into therapy. You may pick from the above or use your own words.

1.

2.

3.

What have you tried on your own, to help yourself with the issues that we will discuss together?

What do you most want to accomplish from coming to therapy? Put information on other side of paper if needed!

Please fill this form out and return to the office when you come for your first appointment! If we are doing Video Chat, we will discuss how you can get this to me.