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For Professional Use Only

Adult Information Form

Psychology and Counseling Associates of Carmel

Name _____ **Age** _____ **Sex** _____
Address _____
City _____ **State** _____ **Zip** _____ **H/Phone** _____
Date of Birth _____ Soc. Sec. # _____ Maiden name _____
Place of employment _____ W/Phone _____
Employment status: Full time _____ Part Time _____ Lay-off _____ Looking _____ Student _____
Disabled _____ Never employed _____ Retired _____ Self employed _____ Unemployed _____ Other _____
Responsible party _____
Referred by:_____ Relationship _____
If yellow pages, what heading did you look under ?_____
Religious preference: Protestant____ Catholic____ Jewish ____Islamic_____ Agnostic_____ Other____ None____
Education: highest grade completed, degree _____
In case of emergency, contact _____ Relationship _____
Address _____ Phone # _____
Reasons for seeking counseling at present time _____
_____
_____

Marital status
Current living arrangement_____ How many living in home _____
Number of dependents (age group) 0-5 _____ 6-12 _____ 13-18 _____
If single: Going steady _____ Engaged _____ How long? _____ No. previous engagements _____
If married: Date married _____ How long dating mate _____ How long engaged _____
Mate's name _____ Age _____ Occupation _____ Education _____
If separated: When separated _____ Previous separations _____
If divorced: When divorced ? _____ Divorce applied for _____ By whom _____
If living together, how long _____ If widowed: How long widowed _____
Previous marriages:

Date	How terminated	Date of termination

Children by present marriage or relationship

Name	Date of Birth	School and grade	Comments

Children by previous marriages			**Children by mate's previous marriages**		
Name	Age	Where residing	Name	Age	Where residing

Health Data

Very good _____ Good _____ Average _____ Poor _____
List present problems including allergies _____
_____
List childhood and other illnesses_____
_____
List any major illnesses or operations_____
_____
When was last medical check up? _____ Are you on any medication ?_____
If yes, please explain: _____
_____
*use back of the page if needed
Your physician _____ phone #_____
Please describe whether you engage in the following habits and approximately how often on weekly, biweekly or monthly basis:
Smoking _____ Drinking _____
Drugs _____ Exercise _____
Have you ever considered or attempted suicide _____ If, yes please explain: _____
_____
Please check if you have been experiencing any of the following problems in the passed two months:
Headaches ( ) Fainting spells ( ) No appetite ( ) Bowel disturbance ( ) Fatigue ( )
Stomach trouble ( ) Insomnia ( ) Take sedatives ( ) Nightmares ( ) Anxiety ( )
Inferiority feelings ( ) Depression ( ) Sexual problems ( )
What other problems or symptoms do you have _____
Have you ever been subjected to any of the following:
Sexual abuse _____ Physical abuse _____ Emotional abuse _____ Verbal abuse _____
If yes, please state by whom and when _____
List all previous counseling, psychotherapy or other treatment for personal or marital problems:
Dates Type of problem Name of professional or agency
_____
_____
_____
_____

Family background

Rate your childhood: Very happy _____ Happy _____ Average _____ Unhappy _____ Very unhappy _____
Parents marital status _____
List your siblings:
Name Age How do you get along with him/her
_____
_____
_____
_____

How do you see yourself? If you were to describe yourself briefly what would you say?
_____
_____
_____
_____