Adult Information Form

(Please print clearly and fill in all information. Thank you)

Name: _____

Preferred Pronouns (Please Circle): She/Her/Hers • He/Him/His • They/Their/Theirs

• Other (_____)

Date of Birth (Month/Day/Year): _____

Street Address:_____
City: _____ State: _____ Zip Code: _____

Phone #'s where I may leave a message:
Cell_____ Home_____ Work _____

Email Address:_____

Are You Presently (please circle all appropriate ones):

Single (Presently) • In Committed Relationship (Presently) • Married (Presently)

• Divorced (Previously) • Widowed (Previously) • Other (_____)

Family Information:
Please name every person living in the home:

Name	Age	Relationship	(Please Leave This Section Blank)

Please list any family members who are no longer living at home:

Name	Age	Relationship	(Please Leave This Section Blank)

Please describe any prior counseling you have had:

Counselor Name	Age	Type of Counseling	Results

Past and present prescribed psychiatric medications:

Drug Name	Prescribed Dose	Length of Time Taking	Results

Emergency Contact (Name, Relationship, Phone #):
_____
_____

Thank you for taking the time to complete this form. It is very useful to have this background information to assist in providing the best care I can deliver. You are invited to update me as needed. If there is information I have not asked about on this form that you feel might be important for me to know, please attach separate sheet(s) and return with this form.

Name (Please Print): _____
Signature: _____ **Date:** _____