ADULT HISTORY FORM

Today's date:

Name: **Birthdate:**

Address:

Phone Numbers: cell

Email

Marital/Relationship Status:

Education:

Occupation:

EMERGENCY CONTACT INFORMATION:

Name:

Contact Number (s):

Address:

Under what circumstances can this person be contacted (check all that apply):

- **Call in an Emergency only**
- **Can use to relay scheduling information**
- **Can all them if therapist can't find patient and needs to relay info**
- **Can share clinical information at therapist's discretion**
- **Please do NOT share clinical information without specific patient permission**

INSURANCE INFORMATION:

Company: **ID:** **Group #**

Effective Date

Insured name:

Contact information:

Authorization number:

<u>PRESENTING PROBLEM(S):</u>

What brought you to counseling at this time?

How long have you been struggling with the above issues?

Have there been any incidents in your life that you believe have caused your problems?

Have you had psychological (counseling) or psychiatric (medicine) treatment before? ______, if yes please complete below:

When & How long	With Whom?	Was it helpful?	Why or why not?

Is there any history of the following in you or your family?

Learning problems Yes _______ No _______ Describe ______________________

Dyslexia Yes _______ No _______ Describe ______________________

Speech problems Yes _______ No _______ Describe ______________________

Mental retardation Yes _______ No _______ Describe ______________________

Hyperactivity Yes _______ No _______ Describe ______________________

Substance abuse Yes _______ No _______ Describe ______________________

Schizophrenia Yes _______ No _______ Describe

____

Depression Yes _______ No _______ Describe ______________________

Suicide Attempts Yes _______ No _______ Describe ______________________

Self Injury Yes _______ No _______ Describe ______________________

Anxiety Yes _______ No _______ Describe ______________________

Obsessive Compulsive Disorder YES/ NO Describe

Suicide Attempts Yes _______ No _______ Describe ______________________

Emotional problems Yes _______ No _______ Describe ______________________

Eating disorders Yes _______ No _______ Describe ______________________

Have you witnessed or experienced any sort of abuse?

Emotional Yes _______ No _______ Describe ______________________

Physical Yes _______ No _______ Describe ______________________

Sexual Yes _______ No _______ Describe ______________________

DO you have any medical problems?

Do you have any allergies to medicines?

Current medications (name and what they are for):

How compliant are you with your medicine regimen?

Habits:

How much alcohol do you drink in a typical week?

Has anyone expressed concern about your alcohol use?

Past and current illicit drug use:

Nicotine Cigarette use?

DO you do any of the following to manage your weight:

- **Restrict your food intake**
- **Excessive exercise**
- **Diet pills**
- **Vomiting**
- **Laxative use or other substances**

FAMILY/SOCIAL BACKGROUND:

Who Raised You? What were they like:

Siblings (name, age, where do they live)

3 Adjectives to describe your childhood:

Any of significant events in your childhood?

Deaths:

Divorces:

Moves:

Illnesses:

Losses:

Traumas:

Life changing events?

Other:

Any of significant events in your recent past?

Deaths:

Divorces:

Births:

Moves:

Illnesses:

Losses:

Traumas:

Life changing events?

Other:

Were you:	**Are You:**			
Adopted	**Married**	_____	**How long?**	________
	Separated	_____	**How long?**	________
	Divorced	_____	**How long?**	________
	Remarried	_____	**How long?**	________
	Committed			

List the name, age, and relationship to you of all persons living in the home:

Name	Age	Relationship

How do you get along with your:

Mother ____

Father ____

Sibling(s) ____

Other family members ____

Any Pet(s) ? ____

If you are in a committed relationship, how would you describe your partner and how would you describe the relationship?

What do you feel are your best qualities?

What qualities get in the way of your being happy?

Any hobbies, talents or interests?

<u>Do you have any problems in the following areas:</u>

Assertiveness

Expressing my feelings

Anger management (too intense)

Anger expression (denies or suppresses anger)

Drinking too much

Drug Use

Impulsivity (acting without thinking):

Infidelity

Trust issues

Binge eating/emotional eating

Over exercising

Undereating

Negative body image

Low self esteem

Self-injury

Legal problems

Over weight or underweight

Nervous in social situations

Excessive guilt

Grief or loss issues

Sleep problems (too much, insomnia, frequent awakenings)

Sexual issues (of any sort)

Vomiting, laxative abuse or other unhealthy forms of weight management

Putting myself last and caring for others too much

Marital Dissatisfaction

Parenting Stress

Unmanageable mood swings

What are your goals for Treatment?

Any fears or concerns about starting treatment?

Anything else I should know?

THANK YOU FOR TAKING THE TIME TO FILL THIS FORM OUT