

Demographic - ADULT

I am excited that you have chosen to start your mental health wellness journey! I want to make the most of each appointment you have. One way of doing this is for you to write down some basic information in advance of your first appointment. Please fill out the following as completely and legibly as possible. The information you provide on this form is confidential and cannot be released to anyone without your explicit written consent. If you have concerns about the relevance of any information requested and wish to leave it out, please feel free to do so.

I. Demographic

Last Name First Name

Date of Birth SSN

Street/Mailing Address Email Address

City/State/Zip

Phone #1 Phone #2
Contact at this number? Yes No Contact at this number? Yes No
Message at this number? Yes No Message at this number? Yes No

Male Female Transgender Other: _____ Decline to State

Birthplace Ethnicity Primary Language

Relationship Status: Single Married Partnered Separated Divorced Widowed

Spouse/Partner's First Name: _____ Length of Relationship: _____

Do you have any children? Yes No
If yes, please provide the following:

Name Age Gender Live with you? Yes No

Name Age Gender Live with you? Yes No

Name Age Gender Live with you? Yes No

Highest Education Achieved: HS/GED AA/AS BA/BS MA/MS Doctorate Other: _____

Are you active military or a veteran? Yes, Active Yes, Veteran Neither Branch: _____

Referred by? _____

II. General Health Information

Do any of the following apply to you?

A. History of...

- Use of tobacco products
- Use of alcohol
- Use of illicit substances
- Misuse of prescription drugs
- Use of caffeine
- Exercise on a regular basis

If checked, please explain...

B. Current...

- Use of tobacco products
- Use of alcohol
- Use of illicit substances
- Misuse of prescription drugs
- Use of caffeine
- Exercise on a regular basis

If checked, please explain...

What else should I know about your general health?

III. Emergency Contact

Last Name

First Name

Address

City/State/Zip

Phone #1

Phone #2

Relationship to client

IV. Employment History

Current Occupation: _____

Employment Status: Currently Working Unemployed Disabled Worker's Comp Retired

What else should I know about your employment history?

V. Medical History

Primary Care Physician (*current*)

Last Name

First Name

Address

City/State/Zip

Phone

Fax

A. Are you *currently* under the care of a medical specialist? Yes No

If yes, please explain type of specialist: _____

B. Have you *ever* been under the care of a medical specialist? Yes No

If yes, please explain when and type of specialist: _____

C. Please list any *chronic illnesses, disabilities, and/or medical conditions* that you have been professionally diagnosed with:

Illness/Disability/Medical Condition

Date Diagnosed

Illness/Disability/Medical Condition

Date Diagnosed

Illness/Disability/Medical Condition

Date Diagnosed

D. Please list any medications, prescription and over-the-counter, you *currently* take for any chronic illnesses, disabilities, and/or medical conditions. Include the name of the medication, what the medication is treating, the dosage (mg), and how often the medication is taken.

Medication

Condition

Dosage (mg) per d/w/m

Medication

Condition

Dosage (mg) per d/w/m

Medication

Condition

Dosage (mg) per d/w/m

When was your most recent physical/check-up? _____

What else should I know about your medical history?

VI. Mental Health History

Psychiatrist (*current*)

Last Name	First Name
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Address

City/State/Zip

Phone	Fax
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Psychologist, Therapist, or Counselor (*current*)

Last Name	First Name
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Address

City/State/Zip

Phone	Fax
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A. Have you ever been under the care of a psychiatrist? Yes No

If yes, please explain:

Dates	Psychiatrist	Circumstances
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Dates	Psychiatrist	Circumstances
-------	--------------	---------------

Dates	Psychiatrist	Circumstances
-------	--------------	---------------

B. Have you ever been in therapy and/or counseling? Yes No

If yes, please explain:

Dates	Therapist/Counselor	Circumstances
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Dates	Therapist/Counselor	Circumstances
-------	---------------------	---------------

Dates	Therapist/Counselor	Circumstances
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C. Have you ever been admitted to a psychiatric hospital? Yes No

If yes, please explain:

Dates	Hospital	Circumstances
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Dates	Hospital	Circumstances
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Dates	Hospital	Circumstances
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D. Please list any *mental health conditions* that you have been professionally diagnosed with:

Mental Health Condition	Date Diagnosed
Mental Health Condition	Date Diagnosed
Mental Health Condition	Date Diagnosed

E. Please list any medications, prescription and over-the-counter, you *currently* take for any mental health conditions. Include the name of the medication, what the medication is treating, the dosage (mg), and how often the medication is taken.

Medication	Condition	Dosage (mg) per d/w/m
Medication	Condition	Dosage (mg) per d/w/m
Medication	Condition	Dosage (mg) per d/w/m

What else should I know about your mental health history?

VII. Trauma History

Check the box next to the events you have witnessed and/or experienced, currently and/or in the past.

- | | |
|---|--|
| <input type="checkbox"/> Natural disaster | <input type="checkbox"/> Terrorist attack |
| <input type="checkbox"/> Human-made disaster | <input type="checkbox"/> Torture |
| <input type="checkbox"/> Serious accident/injury | <input type="checkbox"/> War |
| <input type="checkbox"/> Chemical or radiation exposure | <input type="checkbox"/> Dead bodies (<u>not</u> at a funeral) |
| <input type="checkbox"/> Life-threatening illness | <input type="checkbox"/> Attack with a weapon |
| <input type="checkbox"/> Death of close friend | <input type="checkbox"/> Injury from hitting, spanking, choking, pushing |
| <input type="checkbox"/> Death of family member | <input type="checkbox"/> Forced, unwanted sexual contact |
| <input type="checkbox"/> Kidnapping | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hostage situation | <input type="checkbox"/> Other: _____ |

Please explain:

What else should I know about your trauma history?

VIII. Crisis History

A. Are you *currently* having thoughts of wanting or intending to

- kill yourself?
- die?
- seriously harm yourself (without the intent to die)?

If yes to any, please explain: _____

B. Are you *currently* having thoughts of wanting or intending

- to kill someone else?
- someone else to die?
- to seriously harm someone else (without the intent of death)?

If yes to any, please explain: _____

C. Have you *ever* had thoughts of wanting or intending to

- kill yourself?
- die?
- seriously harm yourself (without the intent to die)?

If yes to any, please explain: _____

D. Have you *ever* attempted to kill yourself? Yes No

If yes, please explain:

Date	Circumstances	Result
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Date	Circumstances	Result
------	---------------	--------

Date	Circumstances	Result
------	---------------	--------

E. Have you *ever* seriously harmed yourself (without the intent to die)? Yes No

If yes, please explain:

Date	Circumstances	Result
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Date	Circumstances	Result
------	---------------	--------

Date	Circumstances	Result
------	---------------	--------

F. Have you *ever* seriously harmed someone else (without the intent of death)? Yes No

If yes, please explain:

Date	Circumstances	Result
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Date	Circumstances	Result
------	---------------	--------

Date	Circumstances	Result
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What else should I know about your crisis history?

X. Symptoms

A. What symptoms do you have and how long have they been active?

B. Do these symptoms affect your activities of daily living? Yes No
If yes, which ones?

- Independent Living Tasks (providing yourself with food, shelter, clothing, and basic living essentials)
- Social/Community Relationships (engaging in meaningful activities, connecting with others)
- Vocational/Educational Responsibilities (accomplishing work and/or school demands and requirements)
- Physical Care Routines (making and attending medical/mental health appointments, self-care)

XI. Strengths and Goals

A. What are your *strengths*? What do people like about you? What do YOU like about you?

B. How would you describe your *self-esteem*?

C. Why have you sought mental health services today?

D. In your own words, what is the nature of the concern that you wish you to address in therapy?

E. What are your *goals* for therapy? What do you want to accomplish?

What else should I know about you?
