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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 | |
|--|--|----------------------------|--|
| Street/Mailing Address | Email Address | | |
| City | State | Zip | |
| Phone #1 Contact at this number? \square N \square Y Message at this number? \square N \square Y | Phone #2 Contact at this number? □ N Message at this number? □ N | | |
| A. □ Male □ Female □ Transgende | er 🗆 Other: | \square Decline to State | |
| B. Birthplace: | Ethnicity: | | |
| C. Highest Education Achieved: ☐ HS/GED ☐ AA/AS ☐ BA/BS | □ MA/MS □ Doctorate □ C | Other: | |
| D. Are you active military or a veteran?☐ Yes, Active - Branch: | _ ☐ Yes, Veteran - Branch: | | |
| E. Referred by? | | | |
| II. Emergency Contact | | | |
| Last Name | First Name | | |
| Address | | | |
| City | State | Zip | |
| Phone #1 | Phone #2 | | |
| Relationship to client | | | |

III. General Health Information

Please fill out the following information:

| Historical | No | Yes | If yes, please explain: | Current | No | Yes | If yes, please explain: |
|----------------|------------------|---------------|-------------------------|----------------|----|-------|-------------------------|
| Use of | | | | Use of | | | |
| tobacco | | | | tobacco | | | |
| products | | | | products | | | |
| Use of | | | | Use of | | | |
| alcohol | | | | alcohol | | | |
| | | | | | | | |
| Use of illicit | | | | Use of illicit | | | |
| substances | | | | substances | | | |
| Misuse of | | | | Misuse of | | | |
| prescription | | | | prescription | | | |
| drugs | | | | drugs | | | |
| Use of | | | | Use of | | | |
| caffeine | | | | caffeine | | | |
| | | | | | | | |
| Daily | | | | Daily | | | |
| exercise | | | | exercise | | | |
| • | nt Sta Vorkii | ntus: ng [| | bled □ Wor | | • | |
| What else sho | uia i i | KIIOW | about your employmen | i ilistory: | | | |
| | | | | | | | |
| V. Medical H | Histo | ry | | | | | |
| Primary Care | Physic | ian (| current) | Applicable | | | |
| | 1119310 | | · | | | | |
| Last Name | | | F | irst Name | | | |
| Address | | | | | | | |
| City | | | | | | State | Zip |
| Phone | | | F | ax | | | |

| A. Are you <u>currently</u> un | der the care of a medical specialist? [| □N□Y | If yes, please explain: |
|--|--|--|-------------------------|
| B. Have you <u>ever</u> been | under the care of a medical specialist? | □N □Y | If yes, please explain: |
| C. Please list any chroniprofessionally diagnosed | ic illnesses, disabilities, and/or medical column \square Not Applicable | onditions that | you have been |
| Illness/Disability/Medical | l Condition | | Date Diagnosed |
| Illness/Disability/Medical | l Condition | | Date Diagnosed |
| Illness/Disability/Medical | l Condition | | Date Diagnosed |
| • | ations, prescription and over the counties, and/or medical conditions. \Box \Box | ter, you <u>curreı</u> lot Applicable | • |
| Medication | Condition | | Dosage (mg) |
| Medication | Condition | | Dosage (mg) |
| Medication | Condition | | Dosage (mg) |
| E. When was your most | t recent physical/check-up? | | _ □ Not Applicable |
| What else should I know | about your medical history? | | |
| VI. Mental Health His | story | | |
| A. Psychiatrist (current) | ☐ Not Applicable | | |
| Last Name | First Name | | |
| Address | | | |
| City | | State | Zip |
| Phone | Fax | | |
| B. Psychologist, Therapi | ist, or Counselor (current) \Box Not Ap | oplicable | |
| Last Name | First Name | | |
| Address | | | |
| City | | State | Zip |
| Phone | Fax | | |

| C. Have you | <u>ever</u> been under the care of a psyc | chiatrist? 🗆 N 🗆 Y | If yes, please explain: |
|--------------------------------------|--|----------------------------------|----------------------------|
| Dates | Psychiatrist | Circumstances | |
| Dates | Psychiatrist | Circumstances | |
| Dates | Psychiatrist | Circumstances | |
| D. Have you | ever received therapy and/or cou | nseling? 🗆 N 🗆 Y | If yes, please explain: |
| Dates | Therapist/Counselor | Circumstances | |
| Dates | Therapist/Counselor | Circumstances | |
| Dates | Therapist/Counselor | Circumstances | |
| E. Have you | <u>ever</u> been admitted to a psychiatri | c hospital? □ N □ Y | If yes, please explain: |
| Dates | Hospital | Circumstances | |
| Dates | Hospital | Circumstances | |
| Dates | Hospital | Circumstances | |
| F. Please list a □ Not Applic | any mental health conditions that y able | you have been professiona | lly diagnosed with: |
| Mental Health | n Condition | | Date Diagnosed |
| Mental Health | n Condition | | Date Diagnosed |
| Mental Healtl | n Condition | | Date Diagnosed |
| | any medications, prescription and conditions. \square Not Applicable | over the counter, you <u>cur</u> | <u>rently</u> take for any |
| Medication | Condition | | Dosage (mg) |
| Medication | Condition | | Dosage (mg) |
| Medication | Condition | | Dosage (mg) |
| What else sho | ould I know about your mental hea | alth history? | |
| VII Trauma | History | | |
| VII. Trauma | • | | |
| | k next to the events you have witn of Applicable | essed and/or experienced, | currently and/or in the |

| | Yes | If yes, please explain: |
|--|-----------------|---|
| Natural disaster | | |
| Human-made disaster | | |
| Serious accident/injury | | |
| Chemical or radiation exposure | | |
| Life-threatening illness | | |
| Death of a close friend, family member, or co-worker | | |
| Suicide of a close friend, family member, or co-worker | | |
| Kidnapping | | |
| Hostage situation | | |
| Terrorist attack | | |
| Torture | | |
| War | | |
| Dead bodies (not at a funeral) | | |
| Attack with a weapon | | |
| Injury from hitting, spanking, choking, pushing | | |
| Forced, unwanted sexual contact | | |
| Other: | | |
| Other: | | |
| Other: | | |
| What else should I know about y | our t | rauma history? |
| VIII. Crisis/Suicide History A. Are you <u>currently</u> having thou □ No □ No □ YES: □ die | l your ? | |
| | • | maini yoursen (without the intent to die): |
| | kill so meon | of wanting or intending omeone else? e else to die? usly harm someone else (without the intent of death)? |
| If yes to any, please explain: | | |

| C. Have you <u>eve</u> □ No | er, in your life, had thoughts YES: \square kill yourself? | of wanting or ir | ntending to |
|---|--|-------------------|---|
| | □ die? | | |
| If you to any play | • | yourself (withou | ut the intent to die)? |
| If yes to any, plea | ise expidifi: | | |
| D. Have you <u>eve</u> | er attempted to kill yourself | ? | If yes, please explain: |
| Date | Circumstances | | Result (Hospitalization, therapy, etc.) |
| Date | Circumstances | | Result (Hospitalization, therapy, etc.) |
| Date | Circumstances | | Result (Hospitalization, therapy, etc.) |
| E. Have you <u>eve</u> If yes, please expl | <u>r</u> seriously harmed yourself ain: | (without intend | ing to die)? \square N \square Y |
| Date | Circumstances | | Result (Hospitalization, therapy, etc.) |
| Date | Circumstances | | Result (Hospitalization, therapy, etc.) |
| Date | Circumstances | | Result (Hospitalization, therapy, etc.) |
| F. Have you <u>eve</u> If yes, please expl | | e else, with or w | ithout the intent of death? $\ \square\ N\ \square\ Y$ |
| Date | Circumstances | | Result (Hospitalization, therapy, etc.) |
| Date | Circumstances | | Result (Hospitalization, therapy, etc.) |
| Date | Circumstances | | Result (Hospitalization, therapy, etc.) |
| What else should | I know about your crisis his | tory? | |
| | | | |
| IX. Family Hist | ory | | |
| A. Relationship S □ Single □ Mar | | rated 🗆 Divor | ced 🗆 Widowed Other: |
| B. Spouse/Partne | er's First Name: | | Length of Relationship: |
| C. Do you have | any children? □ N □ Y | | If yes, please provide the following: Live with you? \square N \square Y |
| Name | | Age Ge | ender Live with you? □ N □ Y |
| Name | | Age Ge | ender Live with you? \[\sum N \ \ \sup Y \] |
| Name | | Age Ge | ender |

| D. Biological Mother: | Deceased | | ed 🗆 Olikilowii 🗀 C | /illel. |
|--|--|---|--|--|
| Last Name | | First 1 | Name | |
| Occupation | | | | |
| E. Biological Father: | Deceased 🗆 | Incarcerated | d □ Unknown □ Otl | ner: |
| Last Name | | First 1 | Name | |
| Occupation | | | | |
| F. Biological parents are: ☐ Single ☐ Married ☐ | | eparated [|] Divorced □ Widowed | Other: |
| G. Do you have any sibli | ings? 🗆 N 🗆 | Υ | If yes, please pr | ovide the following: |
| Name | Age | Gender | Bio/Step/Adopted/Other | Residence |
| Name | Age | Gender | Bio/Step/Adopted/Other | Residence |
| Name | Age | Gender | Bio/Step/Adopted/Other | Residence |
| H. Is there a history of d If yes, please explain: | iagnosed/undiag | nosed ment | al illness in your family? [| □N □Y |
| Relationship: Materna | l □ Paternal | N | lental IIIness: 🗆 Diagnosed | d 🗆 Undiagnosed |
| Relationship: Materna | l □ Paternal | N | lental IIIness: 🗆 Diagnosed | d 🗆 Undiagnosed |
| I. Is there a history of dia□ N □ Y | ngnosed/undiagn | osed substai | nce use disorder/addiction If | in your family? fyes, please explain: |
| Relationship: Materna | l □ Paternal | Substan | ce/Addiction: 🗆 Diagnose | ed 🗆 Undiagnosed |
| Relationship: Materna | I □ Paternal | Substan | ce/Addiction: 🗆 Diagnose | ed 🗆 Undiagnosed |
| What else should I know | about your famil | ly history?_ | | |
| ☐ Social/Community R | ffect your activitionsks (providing you elationships (eng | es of daily l urself with fo gaging in me | iving? | ting with others) |
| | es (making and a | | ng work and/or school demai edical/mental health appo Demographic - ADULT - Page 7 | |

| A. What are your strength. | s? What do people like about you? What do YOU like about you? |
|---|---|
| B. How would you describ | be your self-esteem? |
| C. What are your current of | coping skills? What helps you function now? |
| D. What meaningful activi | ities do you participate in and how often? |
| E. What are your cultural, | spiritual, or religious beliefs, if any? |
| F. Why have you sought n | mental health services today? |
| G. What are your <i>goals</i> fo | or therapy? What do you want to accomplish? |
| What else should I know at | bout you? |
| | |
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| | |
| | |
| | |
| - | whose name appears on the first page of this document and all erein is accurate and true. |
| Client Name (PRINT) | |
| Client (SIGN) | DATE |

XI. Strengths and Goals