MindWorks Psychological Services
7450 Dr. Phillips Blvd. Suite 312, Orlando, Fl 32819
310 S. Dillard Street Suite 160 Winter Garden, Fl 34787
Phone 407.415.1450 Fax 321.234.5587
http://www.MindWorksPysch.com

Adult Client History Form

Full name: _____ Date of birth: _____

Address: _____

Email Address: _____

Age: _____ Gender: Male/Female/Other_____ Ethic identity: C/AA/H/Asian/Biracial/Other

About you:

How did you find out about our clinic, and who referred you?_____
_____
May I thank the person who referred you? N/A, Yes, No_____

Briefly state the main concerns that bring you here today:
_____
_____
_____
_____

How long have you had these concerns? _____
_____

Does anything seem to help? _____
_____

What are your strengths? Coping skills?_____
_____
_____

Family Information:

Tell me about your childhood/parents: _____
_____
_____
_____

Your marital status: ☐Married ☐Divorced ☐Separated ☐Widow/ed ☐Never Married

How many times/length of relationship(s): _____

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Tell me more about the relationship with your spouse/SO_____
_____
_____
_____

Children names and ages:_____
_____
_____

Other (siblings, co-workers, BFFs):_____
_____
_____

Please list all the members of your immediate family:

Name	Age	Relationship to you	Living within household
_____	_____	_____	Yes/No
_____	_____	_____	Yes/No
_____	_____	_____	Yes/No
_____	_____	_____	Yes/No

Family history of medical problems or trauma: (describe)_____
_____
_____

Family history of attention or learning difficulties: (describe):_____
_____
_____

Family history of behavioral, emotional or psychological problems, including frequent use of alcohol or other substances to cope with stress: (describe)_____
_____
_____

Do you know anything about your early childhood development? First words, walking, unusual behaviors or any problems?_____
_____
_____

Pre-school, elementary school and middle school: any concerns with friends, bullying, learning, emotions?
_____
_____

Handedness: ☐Right ☐Left ☐Both (Ambidextrous)

Family history of left-handedness or mixed-handedness? Yes/No (list family members): _____
_____

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Please list counselors, psychotherapists, psychologists and psychiatrists who have seen you:

Age	Provider Name	Service (testing, therapy, treatment, medication)	Helpful
____	_____	_____	Yes/No
____	_____	_____	Yes/No
____	_____	_____	Yes/No
____	_____	_____	Yes/No
____	_____	_____	Yes/No

Psychiatric hospitalizations: Yes/No (describe): _____
Attempted suicide?_____

History of medications for mood or behavior: Yes/No (describe):_____
_____
_____
_____

Have you been diagnosed with a mental health problem or learning disorder in the past? Yes/No
_____
_____

Check all that apply to you now or in the past, circle current symptoms:

___Self-injury ___thoughts about hurting yourself ____thoughts about hurting others
___Family Problems ___Work Problems
___Physical Abuse ___Sexual Abuse
___Alcohol Abuse, frequency _____guilt?____ history in family?_____
___Drug or Prescription Medication Abuse including _____
___recovering addict
___Eating Disorder
___Stressed out
___Difficulty knowing what people mean by their expressions or comments
___Suicidal thoughts
___Suicidal attempts
___Chest pain ___sweating ___chills ____hot flashes ___trembling/shaking
___Addiction to or excessive behaviors (Spending, gambling, porn)
___Body Image Problem
___Hot temper, easily angered
___Nail biting
___Low self-esteem
___Excessive Jealousy
___Hyperactivity
___Difficulty paying attention
___Daydreams frequently
___Frequent crying
___Irritability
___Depression

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___Low energy
___Hopelessness/Helplessness
___Worthlessness
___Social Problems
___Obsessive thoughts
___Sexual difficulties _____
___Excessive need to count, touch objects
___Panic attacks
___Excessive worries or phobias
___Fear of dying
___Fear of going crazy
___Racing thoughts
___Sleep problems, describe_____
___Appetite problems
___Weight loss or gain
___Nightmares
___Excessive fears
___Excessive fantasizing
___Exceptionally sensitive to sounds, tastes, smells or textures_____
___Preoccupation with death
___Hallucinations or delusions
___Unable to think clearly
___Feeling that you are not real
___Feeling things around you are not real
___Losing time
___Do not obey rules/in trouble with the law
___Compulsions
___Rituals or routines you MUST perform (checking, washing)
___OCD behaviors, lining up objects, arranging, ordering etc_____
___Marijuana use
___cigarette smoking
___illicit drug use _____
___Other**:**_____
_____
_____

Medical History:

	Circle One	Ages	Describe
Allergies	Yes / No		
Appetite/eating problems	Yes / No		
Asthma	Yes / No		
Autoimmune problems	Yes / No		
Clumsiness/poor motor skills	Yes / No		
Chronic constipation or IBS	Yes / No		
Congestive heart failure	Yes / No		
COPD	Yes / No		
Diabetes	Yes/ No		

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Headaches	Yes / No		
Head injury	Yes / No		
High Blood Pressure	Yes / No		
Obesity	Yes / No		
Physical disabilities	Yes / No		
Seizures	Yes / No		
Sleep apnea/snoring	Yes / No		
Surgeries	Yes / No		
Tics/twitching	Yes / No		
Vision/eye problems	Yes / No		
Vaccinations	Yes / No		
Alcohol use/abuse	Yes / No		
Illicit drug use/abuse	Yes / No		
Risky behaviors	Yes / No		
Psychosis	Yes / No		

Please add any additional information about the above concerns: _____
_____
_____

Present illnesses for which you are being treated: _____
_____
_____

Current Physician's name, address and phone: _____
_____
_____

Current Medications: Yes/No (if yes, please list):

Name of Medication	Dosage	Name of Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

Difficulties following doctor's advice for medicine or other treatment: Yes/No (describe):
_____

Hospitalizations: Yes/No (describe): _____
_____

School History as an adult:

Name of High School: _____ Graduation year_____ GPA_____

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Tell me what high school was like for you, any problems? AP courses? Struggles with finishing tests, assignments, turning in work, reading comprehension, writing difficulties or failing grades?_____
_____
_____
_____

Did you receive any special education, enrichment or resource services, or attend a gifted and talented program? IEP or 504 plan or accommodations? Yes/No (describe):
_____
_____
Favorite subjects?_____ Difficult subjects?_____

Teachers reported problems in:	Reading	_____	Attention/concentration	_____
	Spelling	_____	Behavior	_____
	Math	_____	Social skills	_____
	Writing	_____	Emotional adjustment	_____

Did you ever receive detention, were suspended or expelled? Yes/No (describe):
_____
_____

Jobs after high school, please list along with any problems (fired,reprimanded etc): _____
_____
_____
_____

Did you attend college?

Two year_____Degree____Area_____GPA_____
Four year_____Degree____Area_____GPA_____
Graduate:_____Degree____Area_____GPA_____
Other (problems, dropped out, testing accommodations, failed courses)_____
_____
_____
_____J

Jobs or extracurricular activities or awards? _____

Describe your spirituality: _____

How do you usually cope with stress? (e.g., talk to someone, work out, cry, write, video games, drink…
_____
_____

Are you involved in any clubs or recreational activities? What do you enjoy doing for fun? Please list:
_____
_____

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Who are you likely to turn to when you need help and support?

_____

_____

Please check any of the following recent stressful events that apply to your family and describe:

- ☐ Relocations: _____
- ☐ Job change: _____
- ○ Accident: _____
- ☐ Deaths: _____
- ☐ Illnesses: _____
- ☐ Marital problems: _____
- ☐ Job changes: _____
- ☐ Someone significant moving out of the area: _____
- ☐ Experiencing a traumatic event: _____
- ☐ Witnessing a traumatic event: _____
- ☐ Physical or sexual abuse or neglect: _____
- ☐ Family and Social Services involvement: _____
- ☐ Legal issues: _____
- ☐ Suicidal thoughts (plan, intent, hospitalization?):_____

Please write any additional remarks you may wish to make regarding your life and situation below and how I may be able to help. Thank you for taking the time to complete this information form. We will review and discuss everything here during your appointment.

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Mental Status Exam:

Orientation: □ person □ place □ time □ circumstance Hygiene/Grooming: □ poor □ good
Posture: □ unremarkable □ rigid □ slumped Eye contact: □ poor □ intermittent □ good
Psychomotor behavior: □ unremarkable □ retarded □ agitated □ involuntary movements □ abnormal gait
Speech: □ WNL for rhythm, rate, and volume □ quiet □ loud □ slow □ rapid □ pressured
□ spontaneous □ hesitant □ dramatic □ slurred □ monotone
Mood: □ neutral □ guilty □ irritable □ angry □ hostile □ anxious □ depressed □ elevated
□ euthymic □ hypomanic □ euphoric □ other:_____
Affect: □ labile □ flat □ blunted □ constricted □ restricted □ mobile □ full ranging
□ congruent with □ inappropriate for: □ circumstances □ reported mood □ situation
Thought Process: □ linear, logical, goal-directed □ mildly circumstantial □ tangential □ loosely connected
Thought Content: □ no evidence of any perceptual disturbances, paranoia, or delusional thinking
□ notable for _____
Insight/Judgment: □ intact □ good □ fair □ poor Impulse Control: □ intact □ good □ fair □ poor

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