5/7/2020

ADULT HISTORY FORM

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and as accurately as you can, you will help me better understand who you are as a person and your life situation. Please answer these routine questions in your own time rather that using up actual consulting time. It is understandable that you might be concerned about what happens to the information about you, because much or all of the information is highly personal. **Case records are strictly confidential! No one is permitted to see your case record without your permission.*********

Date: _____

Name: _____ Age: _____ Sex: _____

Address: _____

_____

Telephone: (Daytime) _____ (Evening) _____

Occupation: _____ Employer: _____

Marital Status: (circle one) Single Engaged Significant Other Partnered Married Separated Divorced Widowed

With whom are you now living? (list people) _____

Who referred you to us? _____

****

In your own words, what difficulties or problems bring you here at this time?

_____

_____

_____

When did these problem(s) first begin? _____

Please estimate the severity of your problem(s):
Mildly upsetting__ moderately severe__ Very severe__ Extremely severe __ Totally incapacitating __

When are these problems worse? _____

When are they better? _____

Have you tried to get any previous help for these problem(s)? _____

If yes, with whom? (Name &Address) _____

Was it successful and why or why not? _____

What important things have happened to you or your family in the last six months? _____

_____

5/7/2020

Personal Data:

Place of Birth: _____ Date of Birth: _____ Height: _____ Weight: _____

Family Physician: _____ Date Last Examined: _____ Findings: _____

How would you describe your current lifestyle?

Currently my health is:

____ Good ____ Fair ____ Poor

I maintain a well-balanced diet:

____ All of the time ____ Occasionally

____ Most of the time ____ Rarely or never

The usual amount of sleep I get per night is:

____ 10 hours or more ____ 7-8 hours ____ Less than 5 hours

____ 9-10 hours ____ 5-6 hours

I exercise: ____ Regularly ____ Occasionally ____ Never

Current/Routine Medications: (i.e. prescription meds, vitamins, laxatives, etc.)

Brand	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical History: (Please circle) Have you had or been told you have any of the following?

Amnesia	Rheumatic Fever	Gout	Sickle Cell Disease	High Blood Pressure
Diabetes	Venereal Disease	Glaucoma	Hypoglycemia	Low blood sugar
Cancer	Stroke	Thyroid Disease	Hepatitis	Tuberculosis
Asthma	Allergies	Heart Disease	Emphysema	Arthritis/Joint Disorder
Epilepsy	Seizure Disorder	Ulcers	Bladder trouble	Head injury

Other: _____

Allergies:	Drugs	Type of Reaction	Food/Other	Type of Reaction
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

What accidents have you had? _____

Have you ever been hospitalized? _____

Substance History:

How long have you been drinking alcohol? _____ How much do you drink? _____

What drugs have you used? _____ Have you ever been arrested for DUI or drug use? _____

Do you smoke? _____ How much do you smoke? _____

Have you ever experienced the following problems/consequences from substance abuse? (please circle if yes)

Legal Employment Marital/Significant Other Family Friends/Peers Military

Educational Health Financial Sexual Other: _____

Please circle any of the following that applied to you during **childhood**:

Night terrors Bedwetting Sleepwalking Thumb sucking Nail Biting Stammering Fears

Happy childhood Unhappy childhood Abuse: (Physical Emotional Verbal Sexual)

Any other occurrences not mentioned: _____

Please Mark: any of the following that apply to you **now:**

	Have Symptom	Being Treated		Have Symptom	Being Treated
Frequent headaches	____	____	No appetite	____	____
Dizziness	____	____	Anger	____	____
Fainting spells	____	____	Take sedatives	____	____
Palpitations	____	____	Insomnia	____	____
Stomach trouble	____	____	Nightmares	____	____
Anxiety	____	____	Feel panicky	____	____
Bowel disturbances	____	____	Alcoholism	____	____
Fatigue	____	____	Feel tense	____	____
Conflict	____	____	Depressed	____	____
Tremors	____	____	Take drugs	____	____
Suicidal ideas	____	____	Sexual problems	____	____
Unable to relax	____	____	Allergies	____	____
Overambitious	____	____	Shy with people	____	____
Can't make friends	____	____	Inferiority feelings	____	____
Can't make decisions	____	____	Lonely	____	____
Can't keep a job	____	____	Memory problems	____	____
Home conditions bad	____	____	Financial problems	____	____
Unable to have a good time	____	____	Often use aspirin	____	____
Often use pain killers	____	____	Difficulty concentrating	____	____
Excessive sweating	____	____	Unusual weight loss	____	____
Excessive tiredness	____	____	Unusual weight gain	____	____
Loss of appetite	____	____	Other: _____		

List your five main fears:

1. _____

2. _____

3. _____

4. _____

5. _____

School History

What is the highest grade you completed? _____ When? _____ Highest Degree _____

Were your grades usually: Above Average ____ Average ___ Below Average ___

What special school problems did you have? _____

Dating and Relationships

How old were you when you began dating? _____ How often did you date? _____

What did you like to do on a date? _____

What problems have there been with the opposite sex? _____

What important people are there in your life now? _____

Is your present sex life satisfactory? _____ Are you sexually inhibited in any way? _____

What was your parent's attitude toward sex? _____

Have you ever experienced any anxiety or guilt as a result of sex? _____

Marital / Significant Other History

How long have you been married to or living with your present spouse/other? _____

How old is he/she? _____ What is her occupation? _____ Education? _____

Personality of spouse/other in your own words: _____

If divorced, tell how and why you separated: _____

_____

Does your spouse/other have a present illness or physical problem? _____ Kind? _____

Do you feel you need to straighten out your relationship? _____ Why and in what way? _____

_____

What kind of person is your spouse/other? _____
How long did you know him/her before you were married? _____
What do you enjoy most about your relationship? _____
_____ Least? _____
Who handles the money? _____ Is there any trouble with this arrangement? _____
_____
How do you get along with your spouse/other's family? _____
How does he/she get along with yours? _____

Children

What are the names and ages of your children? _____
_____
Who disciplines the children and how? _____
What are their present problems and/or illnesses? _____
Which child is easiest to get along with and why? _____
Which child most difficult and why? _____

Job History

What is your present occupation? _____How Long? _____
List your previous jobs and how long at each? _____
How do people on your present job treat you? _____
What problems do you have with the people or with the type of work on your present job or on your last job? _____
_____
If you could have any job you wanted, what kind of job would you choose? _____
_____Why? _____

Family History

Father:

Living or deceased _____ If deceased, your age at time of his death _____ Cause of death _____
If alive, father's age _____ Occupation _____ Education _____ Health _____
Briefly describe your father's personality and his attitude toward you (past and present)? _____
_____

Mother:

Living or deceased _____ If deceased, your age at time of her death _____ Cause of death_____
If alive, mother's age _____ Occupation _____Education _____Health _____
Briefly describe your mother's personality and her attitude toward you (past and present)? _____
_____
In what ways were you punished by your parents as a child? _____
_____
Were your parents ever divorced or separated? _____
Was your home as close, warm, and loving as you wanted? Explain. _____
_____

Siblings:

Number of Brothers: _____ Brothers age's _____
Number of Sisters: _____ Sisters ages _____
Describe your relationship with your brothers and sisters: _____
_____
Were you especially close to any of them? _____
Were you able to confide in your parents? _____
Does any member of your family suffer from alcoholism, epilepsy, or anything which can be considered a mental disorder or an emotional problem?_____
_____

Were you ever sexually approached or molested as a child, adolescent or adult? _____ If so, please describe what happened.

_____

Personal History

Who (besides your parents) has been significant to you in the past: _____

_____

How were they significant? _____

What troubles have you had with the law? _____

Have you ever lost control (e.g. temper or crying or aggression). If so, please explain. _____

_____

_____

What is your main interest outside work? _____

Your religious affiliation _____ How often do you attend church or temple? _____

Who lives in your home with you? _____

Ambitions - Past: _____

Ambitions - Present: _____

Self-description (Please complete the following):

a) I am a person who _____

b) All my life_____

c) When I was a child_____

d) One of the things I feel proud of is _____

e) It's hard for me to admit_____

f) I could be perfectly happy if_____

g) I know it sounds silly but_____

h) One of the things I feel guilty about is _____

i) One of the ways people hurt me is _____

j) Mother was always_____

k) What I needed from mother and didn't get was_____

l) Father was always _____

m) What I needed from father and didn't get was_____

n) The bad thing about growing up is _____

o) One of the ways that I could help myself but don't is _____

p) My fears sometimes force me to_____

q) My most vivid childhood memory is_____

r) I believe most women (men) _____

s) If I had sexual relations_____

t) My sex life_____

u) I like my mother but_____

v) I like my father but_____

Military:

If you are a veteran, what did you do in the service? _____

Highest Rank _____ Where stationed? _____ Discharge date _____

What kind of discharge did you receive? _____

Financial:

What was your family's income last year? _____ How many people did this support? _____

Which medical/hospitalization insurance do you have? _____

Does it cover nervous / mental / emotional problems? _____

Goals:

What is there about your present behavior that you would like to change? _____
_____

What feelings do you wish to change? _____
_____

What do you consider to be your most irrational thought or idea? _____
_____

What benefits do you hope to derive from therapy? _____
_____

Additional Information:

Please list all psychologists, physicians, social workers, counselors, speech therapists, clinic, etc. with which you have had contact. Also please describe any other significant information about you that has not been asked about. Use space below and on the back of this sheet if necessary:

_____
_____
_____
_____
_____
_____
_____
_____