**ADULT INFORMATION FORM**

|  |  |
| --- | --- |
| **NAME:**       | **DATE:**       |
| **REASON FOR VISIT:**       |

**FAMILY AND DEVELOPMENTAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **RELATIONSHIP** | **NAME** | **AGE** | **QUALITY OF RELATIONSHIP** |
| Mother |       |       |       |
| Father |       |       |       |
| Stepmother |       |       |       |
| Stepfather |       |       |       |
| Siblings |       |       |       |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
| Spouse/Partner |       |       |       |
| Child(ren) |       |       |       |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |
|  |       |       |       |

|  |  |
| --- | --- |
| **FAMILY MENTAL HEALTH PROBLEMS** | **WHOM?** |
| Alcohol abuse |       |
| Anger/abusive |       |
| Anxiety |       |
| Depression |       |
| Drug abuse |       |
| Eating disorder |       |
| Hyperactivity |       |
| Manic depression |       |
| Obsessive-compulsive |       |
| Panic attacks |       |
| Schizophrenia |       |
| Sexually abused |       |
| Suicide |       |
| Other:       |       |

|  |  |
| --- | --- |
| [ ]  Parents legally married or living together | [ ]  Mother remarried (Number of times      )  |
| [ ]  Parents temporarily separated | [ ]  Father remarried (Number of times      ) |
| [ ]  Parents divorced or permanently separated | [ ]  Other:       |

Please check if you have experienced any of the following trauma or loss:

|  |  |  |
| --- | --- | --- |
| [ ]  Crime victim | [ ]  Loss of a loved one | [ ]  Physical abuse |
| [ ]  Emotional abuse | [ ]  Multiple family moves | [ ]  Placed a child for adoption |
| [ ]  Financial problems | [ ]  Neglect | [ ]  Sexual abuse |
| [ ]  Homelessness | [ ]  Parent illness | [ ]  Teen pregnancy |
| [ ]  Lived in a foster home | [ ]  Parent substance abuse | [ ]  Violence in home |

**PREVIOUS MENTAL HEALTH TREATMENT**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Yes** | **No** | **Type of Treatment** | **When?** | **Provider/Program** | **Reason for treatment** |
| [ ]  | [ ]  |       |       |       |       |
| [ ]  | [ ]  |       |       |       |       |
| [ ]  | [ ]  |       |       |       |       |
| [ ]  | [ ]  |       |       |       |       |
| [ ]  | [ ]  |       |       |       |       |

**SUBSTANCE ABUSE HISTORY**

|  |  |  |
| --- | --- | --- |
| **Substance Type** | **Current Use (last 6 months)** | **Past Use** |
|  | **Yes** | **No** | **Frequency** | **Amount** | **Yes** | **No** | **Frequency** | **Amount** |
| Alcohol | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Caffeine | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Cocaine/Crack | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Ecstasy | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Heroin | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Inhalants | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Marijuana | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Methamphetamines | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Pain Killers | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| PCP/LSD | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Steroids | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Tobacco | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Tranquilizers | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |
| Other: | [ ]  | [ ]  |       |       | [ ]  | [ ]  |       |       |

**Please check Yes or No for the following questions:**

[ ]  Yes [ ]  No Have you had withdrawal symptoms when trying to stop using any substances?

If yes, please describe:

[ ]  Yes [ ]  No Have you ever had problems with work, relationships, health, the law, etc. due to your

substance use? If yes, please describe:

**MEDICAL INFORMATION**

Date of last physical exam:

Please list any CURRENT health concerns:

Have you experienced any of the following medical conditions during your lifetime?

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Abortion | [ ]  Dizziness/fainting | [ ]  Meningitis | [ ]  Sleep disorder |
| [ ]  Allergies | [ ]  Head injury | [ ]  Miscarriage | [ ]  Stomach aches |
| [ ]  Asthma | [ ]  Headaches | [ ]  Seizures | [ ]  Surgery |
| [ ]  Chronic pain | [ ]  Hearing problems | [ ]  Serious accident | [ ]  Vision problems |
| [ ]  Diabetes | [ ]  High fevers | [ ]  Sexually Transmitted Disease | [ ]  Other |

Current prescription medications: [ ]  None

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dosage** | **Date first prescribed** | **Prescribed by** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

Current over-the-counter medications (including vitamins, herbal remedies, etc.):

Allergies and/or adverse reactions to medications: [ ]  None If yes, please list:

**INTERPERSONAL/SOCIAL/CULTURAL INFORMATION**

Please describe your social support network (check all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Family | [ ]  Neighbors | [ ]  Friends | [ ]  Students |
| [ ]  Community Group | [ ]  Co-workers | [ ]  Support/self-help group | [ ]  Religious/Spiritual Center |

To which cultural or ethnic group do you belong?

If you are experiencing any difficulties due to cultural or ethnic issues please describe:

How important are spiritual matters to you? [ ]  Not at all [ ]  A Little [ ]  Somewhat [ ]  Very much

Would you like spiritual/religious beliefs to be incorporated into your treatment here? [ ]  Yes [ ]  No

Please describe your strengths, skills, and talents:

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):

**MISCELLANEOUS INFORMATION**

**Employment**

|  |  |
| --- | --- |
| Employer: |       |
| Position: |       |
| Length of time in this position: |       |
| Job Duties: |       |
| Stress level of this position: | [ ]  Low [ ]  Medium [ ]  High |
| Other jobs you have held: |       |

**Education**

[ ]  Yes [ ]  No Are you currently attending school?

|  |  |
| --- | --- |
| [ ]  High School Graduate [ ]  GED |  |
| [ ]  Associates Degree Year Graduated:       | Area of Study:       |
| [ ]  Undergraduate Degree Year Graduated:       | Area of Study:       |
| [ ]  Graduate Degree Year Graduated:       | Area of Study:       |

**Military Service**

[ ]  Yes [ ]  No Have you been/are you currently in the military? (If no, skip to Legal section)

|  |  |
| --- | --- |
| Branch: |       |
| Date of Discharge: |       |
| Type of Discharge: |       |
| Rank: |       |
| Were you in combat? | [ ]  Yes [ ]  No  |

**Legal**

[ ]  Yes [ ]  No Have you been convicted of a misdemeanor or felony?

If yes, please describe:

[ ]  Yes [ ]  No Are you currently involved in any divorce or child custody proceedings?

If yes, please describe:

Please add any additional information you may believe is useful for your therapist to know:

|  |  |
| --- | --- |
| Client Signature:  | Date: |