**ADULT INFORMATION FORM**

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

**FAMILY AND DEVELOPMENTAL HISTORY**

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