ADULT HISTORY FORM

Please fill out this form, complete, and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female □ Other

Address: _____
(Street and Number, City, State, Zip Code)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Insurance Type: _____ Policy #: _____

Subscriber's Name: _____ Relationship to Client: _____

Subscriber's SS #: _____ Subscriber's DOB: _____

Referred by (if any): _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Emergency Contact Person (name, phone number): _____

Please list any children/ages: _____

Education Level completed: _____

Are you currently employed? □ No □ Yes, describe: _____

Are you a student? □ No □ Yes, grade and where_____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How many times per week do you generally exercise? _____

3. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

□ Psychiatric Hospitalizations (Date, hospital name, reason): _____

4. Are you currently taking any prescription medication?
□ No
□ Yes, name and dosage: _____

5. Have you ever been prescribed psychiatric medication?
□ No
□ Yes, name and dosage: _____

6. Please indicate the following symptoms:

	When did this start?	How often does it occur?
Depressed mood		
Crying spells		
Decrease in activity		
Decrease in self-care		
Sleeping too much/too little		
Lack of energy/motivation		
Eating too much/too little		
Excessive worry		
Anxiety attacks		
Anger problems		
Irritability		
Increase alcohol use		
Obsessive thinking		
Phobias		
Low self-esteem		
Isolating from others		
Frequent nightmares		

7. Do you have thoughts about harming yourself or someone else?
□ No
□ Yes
If yes, please explain: _____

8. Do you have a history of physical, emotional, or sexual abuse?
□ No
□ Yes
If yes, please briefly explain: _____

9. Are you currently experiencing any chronic pain?
□ No
□ Yes
If yes, please describe _____

10. How much alcohol do you consume in a week? _____

11. How much/what kind of recreational drugs do you use? _____

12. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

13. What significant life changes or stressful events have you experienced recently:

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. What do you consider to be some of your strengths?

_____

_____

2. What do you consider to be some of your weakness?

_____

_____

3. What would you like to accomplish out of your time in therapy?

_____

_____

_____ _____ _____ _____

Client Signature Date Therapist signature Date