

ADULT INFORMATION FORM

Name _____ Date of 1st Appointment _____ Therapist _____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Current medications being taken:

1) _____ Dosage/Freq _____ Start Date _____ Purpose _____

2) _____ Dosage/Freq _____ Start Date _____ Purpose _____

3) _____ Dosage/Freq _____ Start Date _____ Purpose _____

4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems you experience:

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or in school, with peers or teachers? (Circle One) YES NO

If yes, please explain:

What was the last year of school you completed? _____ If you did not complete high school, please explain:

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s) _____	Year(s) _____
(2) School(s) _____	Year(s) _____
(3) School(s) _____	Year(s) _____

would you describe your current support network? (friends, relatives, etc.):

Please check all information which applies to your biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried <input type="text"/> # of times		<input type="checkbox"/> remarried <input type="text"/> # of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your “real” parents? If so, whom?

Where do your parents live?

Mother _____

Father _____

Describe your relationship with your mother while growing up:

Currently:

Describe your relationship with your father while growing up:

Currently:

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse:

Sexual/physical/emotional abuse:

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

sad anxious depressed frightened guilty angry ashamed aggressive resentful
 worthless tearful irritable confused extreme ups/downs jealous hopeless helpless

Describe any other feelings you have had:

What activities or hobbies do you participate in?

Do you participate in regular exercise? (Circle One) YES NO

Describe:

Describe your current working environment:

Have you had any change in sleeping habits? (Circle One) YES NO

Describe:

Have you had any change in eating habits? (Circle One) YES NO

Describe:

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain: _____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.):

THOUGHTS: Please check any of the following that apply to you:

____ I sometimes hear voices even though no one nearby is talking to me.

____ I sometimes feel that forces outside of me control me.

____ I sometimes feel that other people control my thoughts.

____ I sometimes have the same thought over and over and cannot control it.

____ I sometimes feel that someone is out to hurt me or do something against me.

____ I am sometimes unable to control my behavior. Please explain:

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

THANK YOU!