ADULT INFORMATION FORM

Personal Information

Date: _____

Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Address:_____

City: _____ State: _____ Zip Code:_____

Contact Information	Ok to Contact? Y/N
Email:	
Cell:	
Home phone:	

Emergency contact: _____

Relationship to you: _____ Phone: _____

Referral Source (How did you hear about us?) _____

Briefly describe why you are coming in for counseling and the goals you hope to achieve in therapy:

_____

_____

_____

_____

_____

Which of those goals do you feel you need to work on first?

_____

_____

Name _____

Mental Health Information

Symptom Checklist

Check all symptoms that you have experienced in the last 2 weeks. **For checked answers ONLY**, please rate the severity from 1-10, with 10 being most severe.

☑		1-10	☑		1-10
	Loss of interest/pleasure			Sleep disturbances	
	Confusion			Social withdrawal	
	Excessive fatigue			Unwanted/repetitive thoughts	
	Loss of appetite			Panic attacks	
	Nervous habits or rituals (e.g. counting)			Excessive muscle tension	
	Wide mood swings			Excessive nervousness	
	Trouble concentrating			Shortness of breath	
	Weight gain			Feeling very slowed down	
	Weight loss			Dizziness	
	Feelings of worthlessness			Tremors	
	Feeling disconnected to your life			Sweating	
	Excessive irritability			Tingling or numbness	
	Difficulty remembering/mind going blank			Flushes/chills	
	Racing thoughts			Fear of losing control	
	Frequent body complaints (e.g. headaches)			Hallucinations (seeing or hearing things)	
	Distractible			Suspiciousness of people	
	Poor impulse control (e.g. ↑ spending)			Overly rapid/skipping heart beat	
	Unusually energetic			Depressed mood/sadness	
	Physical abuse				
	Sexual abuse				
	Emotional/verbal abuse				

Have you ever been in counseling/therapy before: □ No □ Yes

If yes did you find it helpful? Why or why not?

_____

_____

Are you currently receiving mental health services: □ No □ Yes

If yes, please list name of practitioner and type of services (psychologist, psychiatrist, group therapy):_____

_____

Have you ever been hospitalized for mental health concerns: □ No □ Yes

If yes, list date(s) and reason for admission:

_____

_____

_____

Have you ever been diagnosed with a mental illness? □ No □ Yes
If yes, please list with date(s) first diagnosed:

_____

_____

Have you ever or are you currently self-harming? Current: _____ Past: _____
Have you ever or are you currently contemplating suicide? Current: _____ Past: _____
Have you ever or are you currently contemplating harming another person? Current: ___ Past: _____
Have you ever attempted suicide: □ No □ Yes
If yes please list date(s), method(s), and your age at time of attempt:

_____

_____

Family member committed suicide?: □ No □ Yes
If yes, please list relationship: _____
Has anyone else in your life ever attempted □ No □ Yes or completed suicide: □ No □ Yes
If yes, please list relationship: _____

Family History

Are your parents: □ still together □ divorced, when:_____ □ remarried
□ unmarried □ deceased, if yes whom_____ age at death_____
Number of siblings:_____ Ages:_____
Do you have good family support? □ No □ Yes If yes, from whom? _____

_____

Has anyone in your family (immediate family members or relatives) experienced difficulties with the following? (For any "Y" answers, list family member, e.g., sister, mother, uncle):

Difficulty	Y/N	Family Member(s)
Depression	_____	_____
Bipolar Disorder	_____	_____
Anxiety Disorders	_____	_____
Panic Attacks	_____	_____
Schizophrenia	_____	_____
Alcohol/Substance Abuse	_____	_____
Eating Disorders	_____	_____
Learning Disabilities	_____	_____
Trauma History	_____	_____
Suicide Attempts	_____	_____
Psychiatric Hospitalizations	_____	_____

Spiritual Information

Have you ever or do you currently engage in a personal faith practice: □ No □ Yes
If yes please describe:

_____
_____
_____

Have you ever, or do you currently belong to a faith community (church, synagogue, temple, religious order, etc.): □ No □ Yes
If yes, please describe your current level of connection and involvement:

_____
_____
_____

Do you want to incorporate your faith/spirituality into the counseling process: □ No □ Yes
If yes, please describe how you would like to do so, and if you are specifically seeking spiritual guidance or direction:

_____
_____
_____

Relationship Information

Are you currently in a relationship: □ No □ Yes
If yes, check the status that best describes the relationship:
____ Dating ____ Living Together ____ Engaged ____ Married ____ Separated
Name of Person: _____
How long have you known each other? _____
How long have you been together? _____
Number of marriages: _____ Number of divorces: _____ If widowed, your age at death of spouse: ____

Do you have children? □ No □ Yes If yes, please list below:

Name	Age	Lives with you?	How would you describe your relationship currently?

Are you currently experiencing relationship difficulties you would like to address in individual counseling?
□ No □ Yes If yes, please briefly describe:

_____
_____
_____
_____

Other persons living in your household and your relationship to them:

_____
_____
_____

Health Information

How is your physical health currently? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Date of last physical examination _____

Any chronic health problems or concerns (e.g. asthma, diabetes, headaches, seizures, etc.):

_____
Allergies:_____
Medications:_____
_____

Hours per night you normally sleep _____
Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Can't fall asleep □ Can't stay asleep

Do you exercise regularly? □ No □ Yes
If yes, how many times per week do you exercise? ___ For how long? _____
If yes, what do you do?_____

Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Bingeing □ Purging

Have you experienced significant weight change in the last 2 months? □ No □ Yes

Do you regularly use alcohol? □ No □ Yes
If yes, how often? □ once a month □ once a week □ daily □ daily, 3+

How often do you use recreational drugs? □ Daily □ Weekly □ Monthly □ Rarely □ Never
If you checked any box other than "never," which drugs do you use?
_____

Do you smoke? □ No □ Yes If yes, how many cigarettes per day?_____
Do you drink caffeinated drinks? □ No □ Yes If yes, # per day_____

Have you ever had a head injury? □ No □ Yes
If yes, when and what happened?_____

In the last year, have you experienced any significant life changes or stressors? If yes, please describe:

_____
_____
_____

What do you consider to be your strengths?

_____
_____
_____
_____

What are effective coping strategies you use when stressed?

_____
_____
_____
_____

Is there anything that I did not ask about that would be important for me to know about you?

_____
_____
_____
_____
_____
_____

Occupational, Educational, Legal Information

Are you employed? □ No □ Yes

If yes, current employer/your position: _____

If yes, are you happy at your current position?_____

Please list any work-related stressors, if any: _____

Do you have financial concerns? □ No □ Yes

If yes, please explain: _____

_____

Are you currently in the military? □ No □ Yes Previously? □ No □ Yes

Highest level of education:_____

Do you have any legal concerns? □ No □ Yes If yes, please explain:

_____

_____