ADULT HISTORY FORM

PATIENT NAME: ________________________________ **DATE:** ____________________

IDENTIFYING INFORMATION: Date of birth: ____________________ □ MALE □FEMALE

Identities (Ethnicity, Sexual Orientation, Religious)____
____

Relationship Status: □ Single □ In Committed Relationship □ Separated
□ Partnered/Married □ Cohabitating/Unmarried □ Divorced □ Widowed

Do you have any children? □ No □ Yes If Yes, how many?_______
Children's names/ages: ____

Referred by: □ Self □ Friend □ Parent/Relative □ Attorney □ Doctor □ Other ____________________

PRESENTING PROBLEM AND SYMPTOMS:

____
____
____
____
____

How long has this been a problem? ______________________________

WHAT DO YOU HOPE TO EXPERIENCE WITH COUNSELING? (GOALS)

____
____
____

Please list your strengths (Character/Personality):

____
____

CONCERNS:	**PAST**	**PRESENT/RECENT**	**EXPLAIN:**
Sleeping Concerns	□ N □ Y	□ N □ Y	______________________
Weight or Eating	□ N □ Y	□ N □ Y	______________________
Trauma/Abuse	□ N □ Y	□ N □ Y	______________________
Domestic Violence	□ N □ Y	□ N □ Y	______________________
Sexual Concerns	□ N □ Y	□ N □ Y	______________________
Alcohol Use	□ N □ Y	□ N □ Y	______________________
Drug Use	□ N □ Y	□ N □ Y	______________________
Other Addictive Behaviors (Internet, Porn, Sex, Gaming, Gambling…)	□ N □ Y	□ N □ Y	______________________

Current Suicidal Thoughts ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Past Suicidal Thoughts ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Suicide Attempts ☐ N ☐ Y If Yes, when: ____________ Baker Acted ☐ N ☐ Y If Yes, when: _____________

Thoughts about
Harming Others ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ____

Self-Harming Behaviors (i.e. cutting, burning self, picking, hair pulling, etc.)
____

Do you ever feel unsafe at home? ☐ Yes ☐ No

Are you currently in a relationship in which you have been physically hurt or threatened? ☐ Yes ☐ No

Have you ever been or are you currently concerned about harming your partner or someone close to you?
☐ Yes ☐ No

Have you ever felt afraid of your partner? ☐ Yes ☐ No

FAMILY BACKGROUND: Family Status: ☐ Intact ☐ Divorced ☐ Separated ☐ Other

If married, spouse's name ____

Family History of Mental Illness/Other Disorders:

____

How many siblings do you have? ______________

Relationship with Mother Described As: ☐ Good ☐ Close ☐ Supportive ☐ Distant ☐ Strained

Relationship with Father Described As: ☐ Good ☐ Close ☐ Supportive ☐ Distant ☐ Strained

Do you feel that you currently have adequate social support? ☐ N ☐ Y Explain:

____

OCCUPATION:

Are you currently employed? ☐ Yes, full-time ☐ Yes, part-time ☐ No

If yes, how long have you been employed? ____

Occupation: ____

Are you currently a student? ☐ Yes ☐ No If so, where? ____________________________________

Are you currently receiving disability? ☐ Yes ☐ No

Have you ever been terminated from employment? ☐ Yes ☐ No

Have you been referred by your job's EAP service? ☐ Yes ☐ No

LEGAL HISTORY/SOCIAL AGENCY INVOLVEMENT:

Have you ever been charged with a crime, other than minor traffic offenses? □ Yes □ No

If yes, please explain:____

Have you ever had any involvement with the Department of Children and Families or a similar agency in another state? □ Yes □ No explain: ____

Are you currently involved in litigation in Family Court? □ Yes □ No explain: ________________________

____

Are you currently on probation? □ Yes □ No

MEDICAL HISTORY:

Do you currently suffer from chronic or frequent pain? □ Yes □ No

Do you have any of the following medical conditions?

Diabetes □ Yes □ No

Hypo/Hyper thyroidism □ Yes □ No

PeriMenopause (women only) □ Yes □ No

Frequent Headaches □ Yes □ No

How would you describe your current health? □ Excellent □ Good □ Fair □ Poor

Please list medical conditions affecting emotional health: ____

____

IS THERE ANY OTHER PERTINENT INFORMATION YOU WOULD LIKE ME TO KNOW:

(Academic/work issues, disability, medical problems, childhood info, legal/conduct issues, living situation, etc.)

____

____

____

PREVIOUS COUNSELING/PSYCHIATRIC HISTORY:

□ No Previous Treatment/Counseling □ Previous Counseling □ Psychiatric Treatment

If you have had previous counseling, how would you describe this experience?

____

□ Past Psychiatric Hospitalizations (When, where, how, and how many): ______________________________

____

□ Current Psychotropic medication(s) ____

If you are currently taking medication for a mental health concern, who is the prescribing physician:

____

Explain any of the above:

____

Checklist of Concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add or note details in the space next to the concerns checked.

❒ Abuse—physical, sexual, emotional, neglect (of yourself or someone else)
❒ Aggression, violence
❒ Alcohol use
❒ Anger, hostility, arguing, irritability
❒ Anxiety, nervousness
❒ Attention, concentration, distractibility
❒ Career concerns, goals, and choices
❒ Childhood issues (your own childhood)
❒ Codependence
❒ Compulsions
❒ Decision making, indecision, mixed feelings, putting off decisions
❒ Depression, low mood, sadness, crying
❒ Divorce, separation
❒ Drug use—prescription medications, over-the-counter medications, street drugs
❒ Eating problems—overeating, under-eating, appetite, vomiting, emptiness
❒ Failure
❒ Fatigue, tiredness, low energy
❒ Fears, phobias
❒ Financial or money troubles, debt, impulsive spending, low income
❒ Gambling
❒ Grieving, mourning, deaths, losses, divorce
❒ Headaches, other kinds of pains
❒ Health, illness, medical concerns, physical problems
❒ Inferiority feelings
❒ Interpersonal conflicts
❒ Impulsiveness, loss of control, outbursts
❒ Legal matters, charges, suits
❒ Loneliness
❒ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations
❒ Menstrual problems, PMS, menopause
❒ Mood swings
❒ Motivation, laziness
❒ Obsessions, compulsions (thoughts or actions that repeat themselves)
❒ Over sensitivity to rejection
❒ Panic or anxiety attacks
❒ Parenting, child management
❒ Perfectionism
❒ Procrastination, work inhibitions, laziness
❒ Pregnancy (infertility, miscarriage, termination/abortion)
❒ School problems
❒ Self-esteem
❒ Self-harm (cutting, burning, etc.)
❒ Self-neglect, poor self-care
❒ Sexual issues, dysfunctions, conflicts, desire differences, gender concerns, other
❒ Shyness, over sensitivity to criticism
❒ Sleep problems—too much, too little, insomnia, nightmares
❒ Smoking and tobacco use
❒ Spiritual, religious, moral, ethical issues
❒ Stress, relaxation, stress management, stress disorders, tension
❒ Suicidal thoughts
❒ Weight and diet issues
❒ Withdrawal, isolating
❒ Work problems, employment, work holism/overworking, can't keep a job, dissatisfaction, ambition
❒ Any other concerns or issues: ____ ____________________

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: ____
____

____
____
_____

This is a strictly confidential patient medical record. Disclosure or transfer is expressly prohibited by law.