Aspiring Families
Positive Tools for Thriving Families

Adult Information and History

Today's Date: _____

Personal Information

Name:_____

Home Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Date of Birth: _____

Marital Status: _____

Occupation: _____

Employer/School: _____

Work Address:_____

City/State/Zip: _____

Name of Spouse/Partner: _____

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May we call you …at home? • yes • no …at work? • yes • no

Person completing form (if other than patient):_____

Relationship:_____

Name of Guardian (if applicable):_____

Emergency Contact Information

Contact person in case of emergency:_____

Relationship: _____

Phone #: _____

Physician Information

Primary Care Physician:_____

Phone Number: _____

Referred By: _____

REASON FOR VISIT

Please describe your PRIMARY reasons for seeking therapy/counseling (include year/month the difficulties started):

_____

_____

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_____

_____

Was there a significant event which made these issues or problems surface?

- Yes
- No

If yes, describe:

_____

_____

_____

_____

What motivated you to get help now?

_____

_____

_____

_____

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PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

(Place an X in the appropriate box)

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage						
Family						
Job or School Performance						
Friendships						
Hobbies						
Financial Situation						
Physical Health						
Anxiety Level						
Mood						
Eating Habits						
Sleeping Habits						
Sexual Functioning						
Ability to Concentrate						
Ability to Control your Temper						

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Please answer whether or not you are CURRENTLY experiencing any of the following symptoms:

Suicidal Thoughts/Impulses ..... N____ Y____

Homicidal Thoughts/Impulses ..... N____ Y____

Appetite Problems ..... N____ Y____

Sleep Problems ..... N____ Y____

Physical Complaints ..... N____ Y____

Anger/Irritability ..... N____ Y____

Isolation/Social Withdrawal ..... N____ Y____

Anxiety/Panic ..... N____ Y____

Phobia ..... N____ Y____

Bingeing/Purging ..... N____ Y____

Poor Impulse Control ..... N____ Y____

Violence Toward Others ..... N____ Y____

Destruction of Property ..... N____ Y____

Strange or Unusual Behavior ..... N____ Y____

Confused or Irrational Thinking ..... N____ Y____

Bothersome Repetitive Thoughts or Behaviors N____ Y____

Self-mutilation ..... N____ Y____

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Psychiatric History

Have you received any Psychological/Psychiatric treatment before? No___ Yes___

If you checked Yes to the above question, please answer the following for the most

RECENT TREATMENTS

What was your age at the first visit? _____

What type of care did you receive? • Inpatient (hospital) • Outpatient • Both

When were you in treatment? _____

How long were you in treatment?_ _____

Who was your therapist and psychiatrist? _____

Did your psychiatrist prescribe medicine at this time? • Yes • No • Not applicable

If yes, what was prescribed (include dosages if known)?

_____

_____

_____

_____

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Substance Use History

How much alcohol do you drink per week on average? _____ drinks per week.

How much alcohol did you drink per week on average for the last 5 years? _____ drinks per week.

Have you had problems with your drinking (legal, health, work, relationship)?

No___ Yes___ If yes, please explain:

_____

_____

Have you had any inpatient/hospital treatment for mental health or substance abuse?

No___ Yes___ [If Yes, please list facility(ies) date(s) and length(s) of stay(s)]:

_____

_____

_____

Did you or do you use any illicit drugs? Yes___ No___

Please list:

PAST

_____

_____

PRESENT

_____

_____

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Please describe the alcohol and/or drug use for your PAST and PRESENT USE:

Substances	Amount	Frequency	First Use	Last Use

Do you have a history of blackouts, seizures, or withdrawal symptoms? • Yes • No

Habits:	Amount Currently Using	Most Ever Used
Coffee (cups/day)	_____	_____
Cigarettes (packs/day)	_____	_____
Alcohol	_____	_____

Medical History

Current Medical Condition(s):

_____

_____

_____

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Please list any prescription medications you currently use:

NAME DOSAGE FREQUENCY

_____

_____

_____

Please list any over-the-counter medications you CURRENTLY use:

NAME and DATE BEGAN DOSAGE FREQUENCY

_____

_____

_____

Please list any past or present MEDICAL conditions that you have been treated for:

_____

_____

_____

Have you ever had a brain injury or a neuropsychological exam? Yes___ No___

Please describe:

_____

_____

_____

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When did you last have a physical examination?_____

Whom did you see?_____
Name Phone Number

Do you have any allergies? No___ Yes___ If yes, please list:

_____

_____

_____

Family History

How many siblings did you have? Full _____ Half _____ Step _____

How many times was your mother married? _____

How many times was your father married? _____

Describe any significant conditions of your parents and/or other family members, and please list relationship to family member:

Emotional:

_____

_____

_____

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Medical:

_____

_____

_____

Chemical dependency:

_____

_____

_____

Developmental History

Did you experience any type of developmental delays as a child? Please describe:

_____

_____

_____

Did you experience any type of learning difficulty or academic difficulty as a child? Please describe:

_____

_____

_____

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Goals

Please list your primary goals for treatment in order (begin with the most important):

_____

_____

_____

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