Form Personal—Adult (18+)

Client's name: _____ **Date**: _____

Gender: __ F ____ M **Date of birth**: _____ **Age**: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

Email: _____

How would you like to be contacted? Phone, Email, text

Is it okay to leave you a message on the preferred form of the contact mode?

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services: Please Explain:

Family Information

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.) _____

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____

Marital Status (more than one answer may apply)

Single ___ Divorce in process_____

Unmarried,living together_____ Length of time:____ Legally married ____ Length of time: ____

Separated_____ Length of time: _____ Divorced ____ Length of time: ___

Widowed _____ Length of time:_____ Annulment ___ Length of time: ___

Total number of marriages: _____

Assessment of current relationship (if applicable): Good _____ Fair _____ Poor _____

Parental Information

Parents legally married _____

Mother remarried:_____ Number of times:____

Father remarried:_____ Number of times: ____

Parents ever divorced _____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.):
_____
_____
_____

Development

Are there special, unusual, or traumatic circumstances that affected your development? Yes ___ No ____

If Yes, please describe: _____

Has there been history of child abuse?

Yes ___ No ____

If Yes, which type(s)? Sexual ___ Physical ____ Verbal _____

If Yes, the abuse was as a: Victim ___ Perpetrator _____

Other childhood issues: Neglect_____ Inadequate nutrition _____ Other (please specify):
_____

Comments re: childhood development: _____

_____

Social Relationships

Check how you generally get along with other people: (check all that apply)

Affectionate___ Aggressive____ Avoidant_____ Fight/argue often_____ Friendly ____
Leader ___ Follower____ Outgoing_____ Shy/withdrawn _____ Submissive _____

Other (specify): _____

Sexual orientation: _____ Comments:_____

Sexual dysfunctions? Yes ___ No ____

If Yes, describe: _____

Any current or history of being as sexual perpetrator? Yes __ No___

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes ___ No ____

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters?

Not ___ Little ___ Moderate ____ Much _____

Are you affiliated with a spiritual or religious group? Yes ____ No _____

If Yes, describe: _____

Were you raised within a spiritual or religious group? Yes ____ No _____

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes___ No___

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? Yes ___ No ___

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? Yes _____ No _____

If Yes, please describe: _____

Past History

Traffic violations: Yes ___ No ____

DWI, DUI, etc.: Yes ___ No ____

Criminal involvement: Yes ____ No ____

Civil involvement: Yes ___ No _____

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: _____

Currently enrolled in school? Yes ___ No _____

High school grad/GED _____

Vocational: Number of years: ___

Graduated: Yes ___ No ___ Major: _____

College: Number of years: _____

Graduated: Yes ____ No ____ Major: _____

Other training: _____ Number of years:_____

Graduated: Yes ____ No ____ Major: _____

Special circumstances (e.g., learning disabilities, gifted):

_____

_____

_____

_____

_____

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left	How often missed a day of job

Currently: FT ___ PT ___ Temp ____ Laid-off ____ Disabled ____

Retired ____ Social Security _____ Student ____ Other (describe): _

Military

Military experience? Yes ___ No ___

Combat experience? Yes____ No ___

Where: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity?	How often now?	How often in the past?

Medical/Physical Health

____ AIDS	____ Dizziness	____ Nose bleeds
____ Alcoholism	____ Drug abuse	____ Pneumonia
____ Abdominal pain	____ Epilepsy	____ Rheumatic Fever
____ Abortion	____ Ear infections	____ Sexually transmitted diseases
____ Allergies	____ Eating problems	____ Sleeping disorders

____ Anemia ____ Fainting ____ Sore throat

____ Appendicitis ____ Fatigue ____ Scarlet Fever

____ Arthritis ____ Frequent urination ____ Sinusitis

____ Asthma ____ Headaches ____ Hearing problems

___ Stroke ___ Bed wetting ____ Hepatitis

___ Sexual problems ___ Cancer ____ High blood pressure

____ Chest pain ___ Kidney problems ____ Tuberculosis

____ Chronic pain ___ Toothache ____ Mononucleosis

___Thyroid problems ___ Vision problems ____ Menstrual pain

___ Vomiting ___ Dental problems ____ Miscarriages

____ Diabetes ____ Neurological disorders ____ Diarrhea

____ Nausea

Other (describe): _____

List any current health concerns: _____

List any recent health or physical changes: _____

_____

Current prescribed

medications	Dose	Dates	Purpose	Side effects

Current over-the-counter Meds

Dose	Dates	Purpose	Side effects	

	Date	Reason	Results
Last physical exam			

Last doctor's visit _____ _____ _____

Last dental exam _____ _____ _____

Most recent surgery _____ _____ _____

Other surgery _____ _____ _____

Upcoming surgery _____ _____ _____

Family history of medical problems: _____

_____

Please check if there have been any recent changes in the following:

____ Sleep patterns __ Eating patterns ___ Behavior

____ Energy level ___ Physical activity level

__ General disposition ___ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Chemical Use History

	Method of use	Frequency and amount	Age first used	Age last used	Used in last 48hours	Used in last month
Alcohol	_____	_____	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____	_____	_____
Valium/Librium	_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____	_____
Heroin/Opiate	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____
Over the counter	_____	_____	_____	_____	_____	_____
Prescription drug	_____	_____	_____	_____	_____	_____
Other drugs	_____	_____	_____	_____	_____	_____

Substance of preference

1. _____ 3. _____

2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

_____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

_____

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ___ Self-medication

____ Socialization ____ Taste ____ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

Yes ___ No___

If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes __ No ___

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe):_____

_____

Does your body temperature change when you drink? Yes __ No__

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? Yes __ No___

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes/ No	When	Where	Your reaction to overall experience
Counseling /				
Psychiatric treatment	_____	_____	_____	_____

Suicidal thoughts/

attempts _____ _____ _____ _____

Psychiatric treatment _____ _____ _____ _____

Drug/alcohol treatment ____ _____ _____ _____

Involvement with self-help

groups (e.g., AA, Al-Anon,NA, Overeaters Anonymous)

____ _____ _____ _____

Information about family/significant others (past and present):

	Yes/ No	When	Where	Your reaction to overall experience
Counseling /				
Psychiatric treatment	_____	_____	_____	_____
Suicidal thoughts/				
attempts	_____	_____	_____	_____
Psychiatric treatment	_____	_____	_____	_____
Drug/alcohol treatment	____	_____	_____	_____
Involvement with self-help				
groups (e.g., AA, Al-Anon,NA, Overeaters Anonymous)				
	____	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression	____ Elevated mood	____ Phobias/fears
____ Alcohol dependence	____ Fatigue	____ Recurring thoughts
____ Anger	____ Gambling	____ Sexual addiction
____ Antisocial behavior	____ Hallucinations	____ Sexual difficulties
____ Anxiety	____ Heart palpitations	____ Sick often
____ Avoiding people	____ High blood pressure	____ Sleeping problems
____ Chest pain	____ Hopelessness	____ Speech problems
____ Cyber addiction	____ Impulsivity	____ Suicidal thoughts
____ Depression	____ Irritability	____ Thoughts
____ Disorientation	____ Judgment errors	____ Trembling
____ Distractibility	____ Loneliness	____ Withdrawing
____ Dizziness	____ Memory impairment	____ Worrying
____ Drug dependence	____ Mood shifts	____ Eating disorder

___ Panic attacks ____Disorganized thoughts ___ Other (specify)

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? ___ Yes ___ No

If Yes, explain: _____

Client's Signature : _____ Date: _____

Guardian's Signature: _____ Date: _____

Therapist's signature/credentials: _____ Date: _____