Adult History

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:_____(cell):_____

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

Problem

Primary reason(s) for seeking services:

_____
_____
_____
_____
_____
_____

Briefly describe how the problem has progressed or changed over time:

_____
_____
_____
_____
_____
_____

Family Information

List the primary relationships in your life (such as, children, spouse, parents):

			Living w/ you		Quality of relationship w/ person		
Relationship	Name	Age	Yes	No	Good	Average	Poor
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Marital Status (more than one answer may apply)

☐Single ☐ Divorce in process ☐ Unmarried, living together

Length of time: _____ Length of time: _____

☐ Legally married ☐Separated ☐ Divorced

Length of time: _____ Length of time: _____ Length of time: _____

☐ Widowed ☐Annulment

Length of time: _____ Length of time: _____ Total number of marriages: _____

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

Parental Information

Please tell us about your parents:

☐ Parents legally married ☐ Mother remarried: Number of times: _____

☐ Have parents ever been separated ☐ Father remarried: Number of times: _____

☐ Have 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 ☐ Follower

☐ Friendly ☐Leader ☐ Outgoing ☐ Shy/withdrawn ☐ Submissive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: _____

Legal

Current Status

Are you involved in any active cases (custody, criminal, civil)? ☐ Yes ☐ No

If Yes, please describe the case: _____

_____

Is counseling required as a condition of the case? ☐ Yes ☐ No

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

If Yes, please describe: _____

Any significant legal involvement in your past history?_____

_____

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: _____

_____ Graduate: Number of years: ___ Graduated: ☐Yes ☐No Major: _____

Other training: _____

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

Employment

Current employment:_____

Currently: ☐ FT ☐ PT ☐ Temp ☐ Laid-off ☐ Disabled ☐ Retired

☐ Social Security ☐Student ☐Other (describe): _____

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

List any current health concerns: _____

List any recent health or physical changes: _____

_____

List any prescription or over the counter medications you are regularly taking:_____

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 and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol					☐	☐	☐	☐
Barbiturates					☐	☐	☐	☐
Valium/Librium					☐	☐	☐	☐
Cocaine/Crack					☐	☐	☐	☐
Heroin/Opiates					☐	☐	☐	☐
Marijuana					☐	☐	☐	☐
PCP/LSD/Mescaline					☐	☐	☐	☐
Inhalants					☐	☐	☐	☐
Caffeine					☐	☐	☐	☐
Nicotine					☐	☐	☐	☐
Over the counter					☐	☐	☐	☐
Prescription drugs					☐	☐	☐	☐
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): _____

_____

_____

Have drugs or alcohol created a problem for your job? ☐ Yes ☐ No

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	☐	☐			
Drug/alcohol treatment	☐	☐			
Psych. Hospitalizations	☐	☐			
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	☐	☐			

Any family history of mental health problems, such as addiction, depression, suicide attempts, psychosis (past and present)?

_____

_____

_____

_____

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

☐ Aggression
☐ Alcohol dependence
☐ Anger
☐ Antisocial behavior
☐ Anxiety
☐ Avoiding people
☐ Chest pain
☐ Cyber addiction
☐ Depression
☐ Distractibility
☐ Dizziness
☐ Drug dependence
☐ Eating disorder
☐ Elevated mood
☐ Fatigue
☐ Gambling
☐ Hallucinations
☐ Hopelessness
☐ Impulsivity
☐ Irritability
☐ Loneliness
☐ Memory impairment
☐ Mood shifts
☐ Panic attacks
☐ Phobias/fears
☐ Recurring thoughts
☐ Sexual addiction
☐ Sexual difficulties
☐ Sick often
☐ Sleeping problems
☐ Speech problems
☐ Suicidal thoughts
☐ Trembling
☐ Withdrawing
☐ Worrying
☐ 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: _____

Staff Notes and Family Tree (for staff use only)