ADULT INFORMATION FORM

Name_____ Gender: Male ___ Female ___ Date _____

Date of Birth _____Age _____ SS#: _____

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

Home 'Phone:_____ Cell 'Phone:_____

Employer/Occupation:_____

Work Address:_____City:_____State:_____Zip:_____

Work 'Phone:_____ Length of Employment:_____# of employers in the last 5 years:_____

Presenting Problems (why are you seeking assistance?): _____

_____

_____

FAMILY HISTORY

Your biological parents: MOTHER ____ living ____ deceased FATHER ____ living ____ deceased
____ married ____ married
____ divorced ____ divorced
____ remarried ____# of times ____ remarried ____# of times

Where do your parents live? Mother _____ Father_____

Describe your relationship with your parents:_____

_____

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom? _____

_____

How many siblings do you have?_____

_____

If you will, please describe any family problems which occurred while growing up relating to family instability, alcohol/drug abuse, or sexual/physical/emotional abuse:_____

_____

_____

How would you describe your current support network (friends, relatives, etc.)? _____

_____

Marital Status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Live with Significant Other

If currently married, when were you married? _____ If you are living w/someone, how long? _____

Name of spouse/significant other:_____

Please list your children:

Name	Age	Biological/step/half	Lives with

SCHOOL/VOCATIONAL HISTORY

Last year of school completed? _____ If you did not complete high school, please explain: _____

_____

Did you experience any academic or behavior problems as a child? ___NO ___YES If yes, please explain: _____

_____

Did you pursue further education? _____

What has your employment been? _____

MEDICAL/PSYCHIATRIC HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Phone: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Accidents/Injuries: _____ Head Injuries: _____

Surgeries: _____ Seizures: _____

Broken Bones: _____ Major illness: _____

Pain: ___Yes ___No Where: _____ Severity: 0 to 10 _____

Describe any other medical and/or mental health history about you or your immediate family: _____

_____

Current medications and dose: _____

_____

_____

Name of psychiatric prescriber, if appropriate: _____

Have you ever seen a therapist before: If so, when? _____

Why? _____

Have you ever been hospitalized for psychiatric reasons? ____YES ____NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____

USE OF SUBSTANCES

Do you drink alcohol? ____NO ____YES If no, did you drink previously? ____NO ____YES If yes, please list:

Type: _____ How much: _____ How often: _____

_____ _____ _____

Circle all that are true of you: C-A-G-E

C - Have you ever felt you should cut down on your drinking?

A - Have people annoyed you by criticizing your drinking?

G - Have you ever felt bad or guilty about your drinking?

E - Eye opener: Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Do you use any other intoxicating substances? ____NO ____YES If no, have you used previously? ____NO ____YES

If yes, when did you stop? _____

Type of Drug/How much/How often _____

_____

_____

Do you smoke cigarettes? ___NO ___ YES Use other tobacco: ___NO ___YES If so, what?: _____

MENTAL STATUS

Please check any of the following that describe what you have experienced or how you have been feeling lately:

___sadness	___sleeping more	___anxious	___body pains
___crying more	___sleeping less	___nervousness	___gaining weight
___loss of interest	___irritable	___worried	___losing weight
___loss of pleasure	___jealous	___panic attacks	___restricting food intake
___hopeless	___resentful	___racing heart	___inducing vomiting
___helpless	___angry	___trouble breathing	___confusion
___worthlessness	___aggressive behavior	___frightened	___suspicious of others
___guilty	___feeling tired	___repetitive thoughts	___unusual beliefs
___ashamed	___excess energy	___repetitive behaviors	___visions
___withdrawal	___eating more	___stomach pains	___voices
___mood swings	___eating less	___headaches	___cutting

Describe any other troubling feelings you have had: _____

_____

Have you recently considered suicide? ___NO ___YES Describe:_____

Have you ever considered suicide in the past? ___NO ___YES Describe:_____

Have you attempted suicide recently or in the past? ___NO ___YES Describe:_____

Have you had any thoughts of harming others? ___NO ___YES Describe:_____

Have you seriously harmed someone else in the past? ____NO ___YES Describe: _____

LEVEL OF FUNCTIONING

List or describe any current stressors or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisors, etc.):_____

Who do you count on for support?:_____

What activities or hobbies do you participate in? _____

_____

Do you participate in regular exercise? ___YES ___NO Describe:_____

INTEGRATION OF FAITH IN COUNSELING PROCESS

How important is faith to you in your life?: _____ Significant _____ Moderate _____Very little _____Not at all

Would you like Christian/Biblical principles to be used in therapy?: _____ Yes _____ No

Please name your church affiliation, if appropriate:_____

Would you like for prayer to be a part of the counseling process?: _____ Yes_____ No

Is there any other information regarding you or your family that you would like to share with Dr. Christy that is not covered on this form?_____

_____

What do you hope to change or gain by participating in therapy (goals):_____

_____

How were you referred to Dr. Christy? ___Insurance ___Pastor ___Physician ___Family member ___Friend

___Other Therapist ___Phonebook ___School ___Website ___Psychology networking site

_____ _____

CLIENT SIGNATURE **DATE**