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ADULT CLIENT INFORMATION FORM

This Form is Confidential

Today's data: ________________

Your name: ____
Last First Middle Initial

Date of birth:_________________

Home street address: ____

City: ____ **State**: _______________ **Zip:**__________________

Name of Employer: ____

Address of Employer: ____

City: ____ **State:** _______________ **Zip:**__________________

Home Phone: __________________________________ **Work Phone:** ________________________________

Cell Phone: _____________________________ **Email:**____

Calls will be discreet, but please indicate any restrictions: ___________________________________
____

Referred by: ____

- May I have your permission to thank this person for the referral? __________________________
- If referred by another clinician, would you like for us to communicate with one another? __________

Person(s) to notify in case of any emergency: ____
Name Phone

I will only contact this person if I believe it is a life-or-death emergency. Please provide your signature to indicate that I may do so **(typed name accepted):** ____

Please briefly describe your presenting concerns(s): ___________________________________
____
____
____
____

What are your goals for therapy? ____
____
____
____
____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _________________________________

The following information on this form will help guide your treatment.
Please try to fill out as much as you are comfortable disclosing.*

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: ________________________________
____
____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? ☐ YES ☐ NO If YES, how much per day? ________________________

Do you consume caffeine? ☐ YES ☐ NO If YES, how much per day? ________________________

Do you drink alcohol? ☐ YES ☐ NO If YES, how much per day/week/month/year? __________

Do you use any non-prescription drugs? ☐ YES ☐ NO
If Yes, what kinds and how often? ____

Have any of your friends or family members voiced concern about your substance use? ☐ YES ☐ NO

Have you ever been in trouble or in risky situations because of your substance use? ☐ YES ☐ NO

Previous medical hospitalizations (Approximate dates and reasons): ______________________________
____
____

Previous psychiatric hospitalizations (Approximate dates and reasons) ____________________________
____

Have you ever talked with a psychiatrist, psychologist or other mental health professional? (Please list approximate dates and reasons): ____
____
____

Height _________ Weight (if applicable) __________ Age ___________ Gender ________________________

Sexual Orientation:

☐ Heterosexual ☐ LGBTQIA+ ☐ Prefer not to say

Racial/Ethnic Identity:

☐ African/African American/Black ☐ Latino/Latino-American ☐ Bi-Racial/Multi-Racial

☐ American Indian/Alaska Native ☐ Middle Eastern/Middle Eastern-American

☐ Asian/Asian-American/Asian Pacific Islander ☐ White/European-American ☐ Not listed

FAMILY:

How would you describe your relationship with your mother? ____
____

How would you describe your relationship with your father? ____
____

Are your parents still married? ______________________ If they divorced, how old were you when they separated or divorced, and how did this impact you? ____
____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: ____
____

How many sisters do you have? _________ Ages? ____
How many brothers do you have? ___________ Ages? ____

How would you describe your relationships with your siblings?____
____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____________ How Long? _____ Relationship Satisfaction: 1(poor) to 7(excellent) ___

Married/Life Partnered? ______________ How Long? ______ Previously Married/Life Partnered? ☐ Yes ☐ No

If so, length of previous marriages/committed partnerships____

Do you have Children? ☐ Yes ☐ No If YES, How many and what are their ages: ____________________
____

Describe any problems any of your children are having ____
____
____

List the names and ages of those living in your household:____
____
____

Please briefly describe any history of abuse, neglect and/or trauma: _____________________________________
____
____

Current level of satisfaction with your friends and social support: 1(poor) to 7(excellent) ___________________

Please briefly describe your coping mechanisms and self-care: ____
____
____

Is spirituality important in your life and if so please explain ____
____
____

Briefly describe your diet and exercise patterns: ____
____
____

EDUCATION & CAREER

High School/GED ______________________ College Degree ______________________

Graduate Degree (or Higher) ______________________ Vocational Degree ______________________

What is your current employment? ______________________

Employment Satisfaction: 1(poor) to 7(excellent) ______________________

Any past career positions that you feel are relevant? ______________________

____

What do you think are your strengths? ______________________

____

____

PLEASE CHECK ALL THAT APPLY & PUT A * IN THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
	☐	☐		☐	☐		☐	☐
Anxiety →	☐	☐	People in General →	☐	☐	Nausea →	☐	☐
Depression	☐	☐	Parents	☐	☐	Abdominal Distress	☐	☐
Mood Changes	☐	☐	Children	☐	☐	Fainting	☐	☐
Anger or Temper	☐	☐	Marriage/Partnership	☐	☐	Dizziness	☐	☐
Panic	☐	☐	Friend(s)	☐	☐	Diarrhea	☐	☐
Fears	☐	☐	Co-Worker(s)	☐	☐	Shortness of Breath	☐	☐
Irritability	☐	☐	Employer	☐	☐	Chest Pain	☐	☐
Concentration	☐	☐	Finances	☐	☐	Lump in the Throat	☐	☐
Headaches	☐	☐	Legal Problems	☐	☐	Sweating	☐	☐
Loss of Memory	☐	☐	Sexual Concerns	☐	☐	Heart Palpitations	☐	☐
Excessive Worry	☐	☐	History of Child Abuse	☐	☐	Muscle Tension	☐	☐
Feeling Manic	☐	☐	History of Sexual Abuse	☐	☐	Pain in joints	☐	☐
Trusting Others	☐	☐	Domestic Violence	☐	☐	Allergies	☐	☐
Communicating w/ Others	☐	☐	Thoughts of Hurting Someone Else	☐	☐	Often Make Careless Mistakes	☐	☐
Drugs	☐	☐	Hurting Self	☐	☐	Fidget Frequently	☐	☐
Alcohol	☐	☐	Thoughts of Suicide	☐	☐	Speak Without Thinking	☐	☐
Caffeine	☐	☐	Sleeping Too Much	☐	☐	Waiting Your Turn	☐	☐
Frequent Vomiting	☐	☐	Sleeping Too Little	☐	☐	Completing Tasks	☐	☐
Eating Problems	☐	☐	Getting to Sleep	☐	☐	Paying Attention	☐	☐
Severe Weight Gain	☐	☐	Waking Too Early	☐	☐	Easily Distracted by Noises	☐	☐
Severe Weight Loss	☐	☐	Nightmares	☐	☐	Hyperactivity	☐	☐
Blackouts	☐	☐	Head Injury	☐	☐	Chills or Hot Flashes	☐	☐

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems	☐	Physical Abuse	☐	Depression	☐
Legal Trouble	☐	Sexual Abuse	☐	Anxiety	☐
Domestic Violence	☐	Hyperactivity	☐	Psychiatric Hospitalization	☐
Suicide	☐	Learning Disabilities	☐	“Nervous Breakdown”	☐

Any additional information you would like to include:____