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ADULT CLIENT INFORMATION FORM

(09/14/21)

This Form is Confidential Today's Date: _____

Client name: _____
Last First Middle Initial

Preferred name: _____ DOB: _____ Age: _____

Home address: _____
Street City State Zip

Phone: _____
Home Cell Work

Employer: _____

Employer Address_____
Street City State Zip

Position: _____ Time in current position:_____

Email: _____

Highest Level of Education Completed: _____

Relationship Status: ☐ **Single** ☐ **Committed Relationship** ☐ **Domestic Partnership** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Spouse/Significant other's name: _____

Time in Relationship: _____ Time Separated/Divorced/Widowed: _____

How did you hear about us? ☐ **Family/Friend** ☐ **Physician/Psychiatrist** ☐ **Social Media** ☐ **Internet Search** ☐ **Psychology Today**

Referral Name: _____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person to notify in case of 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: (Your Signature): _____
Client Signature **Date**

Please briefly describe your presenting concern(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)?_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses:_____

_____

_____

_____

Current Medications (if you need more room, please write on the back of this page):

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? (If yes, please list approximate dates and reasons): _____

_____

_____

Sexual & Gender Identity:

__ Heterosexual __Lesbian __Gay __Bisexual

__Transgender __ Asexual __In Question __Other: _____

Racial/Ethnic Identity:

__African/African-American/Black

__American Indian/Alaska Native

__Asian/Asian-American/Asian Pacific Islander

__Bi-Racial/Multi-Racial

__ Latino/Latino-American

__ Middle Eastern/Middle Eastern-American

__White/European-American

__Not listed

FAMILY:

Rate and describe the current relationship with your mother: POOR 1 2 3 4 5 6 7 8 9 10 EXCELLENT

_____

_____

Rate and describe the current relationship with your father: POOR 1 2 3 4 5 6 7 8 9 10 EXCELLENT

_____

_____

Are your parents still married or did they divorce?_____ If divorced, how old were you when your parents separated or divorced and how do you think this impacted you? _____

_____

Please describe the relationship with your grandparents: _____

_____

_____

Were there any other primary care givers who have had a significant relationship in your life? If so, please describe how these people may have impacted your life: _____

_____

_____

How many sisters do you have? _____ Ages? _____Names: _____

How many brothers do you have? _____ Ages? _____Names: _____

How would you describe the relationships with your siblings?_____

_____

_____

_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

POOR EXCELLENT

Your current level of satisfaction with friends and social support: 1 2 3 4 5 6 7 8 9 10

How would you describe the relationships with your peers? _____

_____

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

_____

_____

Please briefly describe your self-care and coping skills: _____

_____

_____

What is your current diet, weight, and exercise/activity patterns?_____

_____

_____

Please briefly describe your work performance and experience:_____

_____

_____

POOR EXCELLENT

Your current level of satisfaction with employment / position: 1 2 3 4 5 6 7 8 9 10

What are your hobbies, talents, and strengths?_____

_____

_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	
PAST								
Anxiety →			Tantrums →			Nausea →		
Depression			Parents Divorced			Stomach Aches		
Mood Changes			Seizures			Fainting		
Anger or Temper			Cries Easily			Dizziness		
Panic			Problems with Friend(s)			Diarrhea		
Fears			Problems in School			Shortness of Breath		
Irritability			Fear of Strangers			Chest Pain		
Concentration			Fighting with Siblings			Lump in the Throat		
Headaches			Issues Re: Divorce			Sweating		
Loss of Memory			Sexually Acting Out			Heart Problems		
Excessive Worry			History of Child Abuse			Muscle Tension		
Wetting the Bed			History of Sexual Abuse			Bruises Easily		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Makes Careless Mistakes		
Separation Anxiety			Hurting Self			Fidgets Frequently		
Alcohol/Drugs			Thoughts of Suicide			Impulsive		
Drinks Caffeine			Sleeping Too Much			Waiting His/Her 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		
Head Injury			Sleeping Alone			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:

_____

_____

_____

_____