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Adult History Form

Name: _____ Date: _____

Relational Information

Marital status: ____ Single ____Engaged ____Married ____Separated ____ Divorced ____Widowed

If engaged, married, divorced or widowed, how long have you been so? _____

Number of previous marriages for you? _____ For your current spouse? _____

Name of spouse: _____ Spouse's age: _____

Spouse's Occupation: _____

Please provide a brief description of your spouse (e.g., angry, controlling, outgoing, supportive): _____

_____

Family of Origin

Please list your mother, father, brothers, sisters, stepfamily and/or relatives who had a significant effect upon your life (positive or negative).

Name	Sex	Age/Year of death	Relationship to you	Describe him/her

Please identify any of the following you experienced in your family:

____ Physical Abuse ____ Emotional Abuse ____ Sexual Abuse ____ Abortions ____ Gambling
____ Drug/Alcohol Addiction ____ Religious Upbringing ____Major Losses ____Multiple Marriages

Please describe the kind of family you grew up in: _____

_____

_____

Counseling History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the name of the therapists and/or programs (use back of this sheet if necessary):

Name of Therapist/Program	Issues Addressed	Dates in Treatment

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? **Yes** **No**
If yes, please describe: _____

Have any of your family or friends ever attempted or committed suicide? **Yes** **No**
If yes, who and when: _____

Medical History

Name and Address of Current Physician: _____

Date and outcome of last physical exam: _____

Please list any conditions, illnesses or surgeries that might be relevant to your reason for seeking counseling:_____

Please list current medications you are taking even if use is seldom or as needed (use back of sheet if necessary):

Name of Medication	Dosage	Reason for taking medication

Check any of the flowing symptoms or problems that you are currently or have recently experienced:

☐ Stress	☐ Grief	☐ Verbal abuse	☐ Impulsive behavior	☐ Anxiety
☐ Chronic pain	☐ Sexual abuse	☐ Controlling	☐ Sexual problems	☐ Fears
☐ Loneliness	☐ Sexual addiction	☐ Obsessive thoughts	☐ Depression	☐ Panic
☐ Indecisiveness	☐ Poor concentration	☐ Shyness	☐ Gender identity	☐ Anger
☐ Bad dreams	☐ Low self-esteem	☐ Hearing voices	☐ Loss of appetite	☐ Fatigue
☐ Marital problems	☐ Aggression	☐ Racing thoughts	☐ Trouble sleeping	☐ Apathy
☐ Relational issues	☐ Eating problems	☐ Physical Abuse	☐ Compulsive behavior	☐ Alcohol use
☐ Feeling worthless	☐ Emotional Abuse	☐ Loss of control	☐ Pregnancy/Abortion	☐ Work issues
☐ Financial issues	☐ Spiritual apathy	☐ Drug use	☐ Career choices	☐ Loss
☐ Unwanted memories	☐ Controlled by others		☐ Seeing things others don't	

Present Issues and Goals

Please describe your personal strengths:

_____

_____

Please describe specific challenges you are facing:

_____

_____

Please list people and activities that are currently a positive influence in your life:

_____

_____

Please place an "X" on the scale to indicate how much distress your are experiencing at this time.

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Very minimal distress Moderate distress Very extreme distress

Are you currently experiencing any suicidal thoughts? _____YES _____NO

If YES, please explain:_____

Have you experienced suicidal thoughts or attempted suicide in the past? _____YES _____NO

If YES, please explain:_____

Are you currently experiencing any violent or homicidal thoughts? _____YES _____NO

If YES, please explain:_____

_____ _____

Client's Signature Date