

**ADULT INFORMATION SHEET**

Please provide the information requested on both sides. Be as accurate as you can. Your responses are confidential information and will not be released to anyone without your written permission.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: F  M

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Educational Level Completed: \_\_\_\_\_

**In case of emergency, please notify:** Name: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening: \_\_\_\_\_

**Marital Status** (circle one):  Single  Married  Separated  Divorced  Remarried  Widowed

Previous Marriage:  Yes  No

Occupation: \_\_\_\_\_

Employed: \_\_\_\_\_ How Long? \_\_\_\_\_

**Medical History** (please give brief statement regarding the following):

Hospitalizations/surgeries: \_\_\_\_\_

Serious injuries/illnesses: \_\_\_\_\_

Chronic medical conditions: \_\_\_\_\_

Current prescription or over-the-counter medications: \_\_\_\_\_

Physician: \_\_\_\_\_

Allergies: \_\_\_\_\_

Drug Sensitivities: \_\_\_\_\_

Smoking (how much/how long): \_\_\_\_\_

Alcohol or other drug use: \_\_\_\_\_

Military: Branch: \_\_\_\_\_ Year of Discharge: \_\_\_\_\_ Type: \_\_\_\_\_

Legal History: \_\_\_\_\_

(over)

**Family History** – Record age, state of health or cause of death, history of alcoholism and/or mental health.

Father: _____	Spouse/Life Partner: _____
Mother: _____	Children: _____
Brother(s): _____	_____
_____	_____
Sister(s): _____	_____
_____	_____

Others residing in home: \_\_\_\_\_

Use the scale below to number the response which best describes problems you may have in the following:

<b>4-Severe Problem</b>	<b>3-Moderate Problem</b>	<b>2-Minimal Problem</b>	<b>1-Not a Problem</b>
Depression	4 3 2 1	Sexual abuse	4 3 2 1
Suicidal thoughts	4 3 2 1	Sexual problems	4 3 2 1
Suicide attempts	4 3 2 1	Sexual orientation issues	4 3 2 1
Anxiety-Excessive Worrying	4 3 2 1	Thoughts of hurting others	4 3 2 1
Panic attacks	4 3 2 1	Anger/violence (actual/threatened)	4 3 2 1
Changes in eating patterns	4 3 2 1	Alcohol/other drugs (self)	4 3 2 1
Sleep problems	4 3 2 1	Alcohol/other drugs (other)	4 3 2 1
Bulemia/Anorexia	4 3 2 1	Gambling problems	4 3 2 1
Withdrawn behavior	4 3 2 1	Marital/relationship problems	4 3 2 1
Health problems	4 3 2 1	Legal difficulties	4 3 2 1
Job related problems	4 3 2 1	Grief issues	4 3 2 1
Parent-child conflict	4 3 2 1	Low self-esteem	4 3 2 1
Physical abuse	4 3 2 1	Blended family issues	4 3 2 1
Brother-sister problem	4 3 2 1	Dysfunctional family/origin issues	4 3 2 1
		Other	4 3 2 1

Have you ever:	Been hospitalized for emotional problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Participated in outpatient therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Participated in self-help group?	<input type="checkbox"/> Yes <input type="checkbox"/> No

List goals that you hope to achieve in counseling: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Client's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Guardian's Signature (if client is minor)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Counselor's Signature

\_\_\_\_\_  
 Date