Last Name____________________

Adult History Form

If you object to any question, please skip it.

Name/s: ____
Phone 1:_____________________________ Phone 2:_____________________________
Address:____
Email: ____
Date of Birth: ___/___/_____ Age:______ Place of Birth:_____________________________
Gender you identify with: ______________ Sexual Orientation _______________________
Ethnicity/ies you identify with: ____
Other places you have lived: ____
____

Preferred type of contact? ☐Phone 1 ☐Phone 2 ☐E-Mail(not a secure format)
Are you active military? Where? ____
Are you a veteran? Explain more:____
____
What education/training have you had: ____
____

EMERGENCY CONTACT:
Name of Emergency Contact_______________________________ Relationship___________
Phone: ______________________________ E-mail _______________________________

CURRENT LIVING ARRANGMENTS:
Others in household: Name, Age, and Relationship to You
____
____
Describe your living situation (renting, own, homeless) ________________________________

GOALS:
What are your reasons for coming into therapy? _____________________________________
____
What symptoms do you experience?____
____
When did these things begin to bother you? ____
Are there any immediate situations that you need an action plan for right now? (are you in danger, family reunions, tests, anything upcoming that your are extremely worried about) ____
____
____
How will you know that therapy has been successful for you?___________________________
____
____
If therapy is successful would there be a downside? Would anyone in your life have a problem with your changes?____
____
What are your fears around receiving therapy? _______________________________________
____

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PRESENT RELATIONSHIPS: (Genogram in office)
Who are you closest to at this point in your life? ____________________________________
____
Who has been the biggest support in your life? ____________________________________
____
Describe your relationships with your parents: ____________________________________
____
____
____
Do you have siblings? __________ Are you close to them? ___________________________
What does your relationships look like with your sibling/s? ___________________________
____
____
Are you in a romantic relationship with anyone?____________ What does this relationship look like?____
Do you have a child/children? Please list ____
____
Do you care take of another person? Please list _____________________________________
____
Do you have family that lives near by? ____
Do you have a close group of friends? ____
Are you currently employed? ____ Where:______________ How do you feel about your job?
____
Do you get along with your co-workers?__________ Who are you closest to at work ?________
How would you describe your relationship with your boss?_____________________________
____

MEDICAL HISTORY:
Have you been told you are at high risk for contracting HIV or an STIs? Why?
____
Explain your safe sexual contact practices: ____
____
Who is your primary care physician? ____________________ List all other medial personal you work with: ____
Were there any problems with the your birth? Or pregnancy of your mother? _______, If yes, What? ____
____
Did you have any serious illnesses or accidents while growing up? ______________________
____
____
____
Have you ever been pregnant? Are you pregnant or trying now?________________________
Have you had any of the following?:

- Falls or blows to the head that left you dazed?______ That knocked you out?______ That caused confusion?______ If yes explain:__________________________________
  ____
  ____
- Seizures? _______ Describe: ____
  ____
- Visual problems?_____ Hearing problems?________ Frequent headaches?________

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- Do you have any other health problems that need to be considered? (e.g. allergies, heart problems, diabetes) Explain: ___________________________________
  ____
  ____

Check any of the following that apply to you:

	Nightmares		Stealing		Fire Setting		Nail Biting
	Running Away		Easy to anger		Speech Problems		Bullying
	Lying		Shy		Daydreaming		Sleepwalking
	Loneliness		Sleep Problems		Depression		Anxiety
	Friendless		Hyperactive		Anger Outburst		Felt Helpless
	Fear of unknown		Difficult to focus		Felt Hopeless		Easily Distracted
	Afraid of Social interaction		Moody		Racing Thoughts		Bullied/ Blamed
	Try to be perfect		Miss appointments often		Wish for death		Not able to express feelings
	Developmental delays		Issues around cleanliness		Not able to calm self down		Sexual Problems
	Digestive Problems		Panic Attacks		Energy Change		Other ___________ ________________

Please list any medication, vitamins/supplements, or homeopathic remedies you use:

Current Medication	Prescribed for	Dosage/ Times per day	Prescribing Doctor	Date Started

LEGAL INVOLVEMENT

Have you ever been picked up by the police? ______ Why? (List all things like shoplifting, petty theft, runaway, possession, consumption, assault, distribution, DUI, Etc.) ____________________
____
____

Do you have a probation officer? ____

Do you have any pending court cases? For what?_____________________________________

Have you been a victim of a crime? Please explain _____________________________________
____

Please list any current legal cases (custody, protection orders, and criminal cases), the date and location ____________.____
____

Last Name_____________________

COUNSELING AND TREATMENT HISTORY:

Have you ever received counseling, therapy or mental health treatment? _______ If yes, where and what diagnosis have you been giving? ____

____

What kind of therapy was it?____

What was the focus of this therapy or treatment? _____________________________________

____

Did you get along with your therapist?____

What did you like most about therapy?____

____

What did you not like about therapy?____

____

Why did you stop therapy or treatment? ____

Tell me about your overall experience of therapy ____________________________________

____

____

____

FEELINGS:

How do you feel most of the time? ____

What sort of things are you happy about? ____

____

Sad? ____

Angry?____

Nervous?____

In the past six months, have there been any changes in your appetite?_______ your weight?____

If yes, where you on a diet or other program? _______________________________

Do you feel overweight/underweight?_________ By how much?________________________

Describe how you sleep: ____

Have you ever had times when your mood went up and down quickly?_____ How often does that occur?____

What do you do when you really want something and you don't get your way? _____________

____

____

Do you ever get into fights?_____ with whom?_______________________________________

Are you bothered by recurrent, unwanted ideas, images, worries, impulses, or thoughts that seem silly, nasty or horrible? ____

When these thoughts come into your head how do you feel?________________________

Do you think you are unable to get rid of these ideas?____________________________

Do you worry about being embarrassed or humiliated in social situations?__________________

____

Have you had problems with anxiety, tension or worrying? ______________________________

____

Is there anything you would change about yourself?____ Why?___________________________

____

____

Do you have a religious faith or spiritual belief?______________________________________

How does your spirituality support you? ____

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How do you usually deal with stress?____
____
____
____

What kinds of hobbies or fun activities are you involved in? ______________________________
____
____

SUBSTANCE USE HISTORY

What drugs or substances do you use? (Include Alcohol in table)

Substance	**Used within last 30days**	**Frequency** Daily, 3-5x week, 2-3x week, 1x week, 2 month	**Form of use** Pills, smoking ,injection, other	**Age when started**

Does using drugs cause problems in your life now? Explain ______________________________
____
____

Have Drugs or Alcohol ever caused a problem in your life in the PAST? Explain _____________
____
____

OTHER SIGNIFICANT FACTORS:

Has there been past abuse/violence in the home?________ If yes, was it reported to Human Services?____ How long ago did this happen? _______________________________________

Check all types of abuse you **witnessed**:

☐ Verbal ☐ Emotional/mental ☐ Physical ☐ Sexual

Check all types of abuse you **experienced**:

☐ Verbal ☐ Emotional/mental ☐ Physical ☐ Sexual

Have you ever felt unsafe in an intimate relationship? Either due to verbal, mental, physical or sexual abuse/violence, coercion, threats or intimidation?? ______________________________

What effects of has this abuse/violence had on you? ___________________________________
____
____
____

Is there anything else you would like the therapist to be aware of? _______________________
____
____
____
____
____