Adult Information Form

Client name: _____

Client Name:_____ Age:_____ DOB:_____ Today's Date _____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: ( ) _____ Ok to leave message? __ YES __ NO
Work Phone: ( ) _____ Ok to leave message? __ YES __ NO
Current Employer (or school if a student): _____
Gender: Male __ Female __ Who referred you to Cornerstone: _____

WHO MAY WE CONTACT IN CASE OF EMERGENCY: _____
Daytime Phone: ( ) _____ Evening Phone: ( ) _____
Spouse's Name (if applicable): _____ Age: _____ DOB: _____

Current Marital Status

__ Single (duration: _____)
__ Married (duration: _____)
__ Unmarried, living together (duration: _____)
__ Separated (duration: _____)
__ Divorcing (duration: _____)
__ Divorced (duration: _____)
__ Widowed (duration: _____)

Education

Currently in school: __ YES __ NO Total years of education: _____

__ High School Graduate
__ G.E.D.

			Major area(s) of study/training
__ Vocational:	# of years ___	Graduated: __ YES __ NO	_____
__ College:	# of years ___	Graduated: __ YES __ NO	_____
__ Graduate School:	# of years ___	Graduated: __ YES __ NO	_____

Special Services? (special education, learning disabilities, etc) _____

Employment

Are you currently employed: __ YES __ NO
Current Employer: _____ Job Title: _____
Length of time employed: _____ Job responsibilities: _____
Level of stress of job: _____ Other jobs you have worked: _____
_____

Legal

Are you involved in any legal activities (civil, criminal, custody, probation/parole, etc)? __ YES __ NO
If yes, please describe: _____
Past History:
Traffic Violations: __ YES __ NO DUII/DWI, etc.: __ YES __ NO
Felony/Misdemeanor charges? __ YES __ NO Civil/custody lawsuits: __ YES __ NO

Military Experience

Military experience? __ YES __ NO (if no, skip this section)
Branch of Service: _____ Date enlisted/drafted: _____
Discharge date: _____ Type of discharge: _____ Rank at discharge: _____
Combat experience?: __ YES __ NO Other stressors experienced:_____

Therapist Notes: _____
_____
_____
_____

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PRESENTING PROBLEMS/CONCERNS

Describe the problem that brought you here today: _____
_____

What do you hope to gain from therapy: _____
_____

Please check behaviors and symptoms that occur to you more often than you would like:

__ Aggression/fighting
__ Alcohol abuse
__ Angry outbursts
__ Arguments/conflicts
__ Anxiety
__ Avoiding people
__ Chest pain
__ Computer addiction
__ Depression
__ Disorientation
__ Distractibility
__ Dizziness
__ Drug abuse
__ Eating disorder
__ Elevated mood
__ Fatigue
__ Gambling
__ Hallucinations
__ Heart palpitations
__ High blood pressure
__ Hopelessness
__ Impulsivity
__ Irritability
__ Judgment errors
__ Loneliness
__ Memory impairment
__ Mood swings
__ Panic attacks
__ Phobias/fears
__ Recurring thoughts
__ Sexual addiction
__ Sexual difficulties
__ Frequent illness
__ Sleeping problems
__ Speech problems
__ Suicidal thoughts
__ Thoughts disorganized
__ Trembling
__ Withdrawing
__ Worrying
__ Other (specify)
__ _____
__ _____
__ _____

Briefly describe how the above checked symptoms impair your ability to function effectively: _____
_____
_____

Have you ever had thoughts or made statements of wanting to hurt yourself or seriously hurt someone else? __ YES __ NO. If YES, please describe the situation: _____
_____

Have you ever purposely hurt yourself or another? __ YES __ NO. If YES, please describe the situation: _____
_____
_____

PRIOR MENTAL HEALTH TREATMENT

Type of Treatment	No	Yes	Start/End Dates	Provider name/ primary reason for treatment
Counseling or Psychiatric Care:				
Drug/Alcohol Treatment:				
Psychiatric Hospitalization:				
Medication for mental health problem:				
Self-help/support group:				

Therapist Notes: _____
_____
_____
_____

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FAMILY & DEVELOPMENTAL HISTORY

Relationship	Name	Age	Deceased?	Quality of relationship	Family mental health problems?	Who?
Mother:					Depression	
Father:					Anxiety	
Stepmother:					Sexual abuse	
Stepfather:					Attention deficit	
Spouse/partner:					Alcohol abuse	
Children:					Drug abuse	
					Schizophrenia	
					Manic-Depression	
					Imprisonment	
Siblings:					Suicide	
					Eating disorders	
					Panic attacks	
					Obsessive/compulsive	

Parental Marital Information:

__ Parents legally married
__ Parents have been separated
__ Parents divorced

__ Mother remarried: Number of times _____
__ Father remarried: Number of times _____

Is there anything happening NOW in your current living situation or in your family that is especially stressful for you?

_____
_____

Please check if you have suffered any of the following types of trauma:

__ Neglect
__ Sexual abuse
__ Teenage pregnancy
__ Violence in the home
__ Parental illness
__ Multiple family moves
__ Emotional abuse
__ Loss of loved one
__ Parental substance abuse
__ Parents separated or divorced
__ Homelessness
__ Other: _____
__ Physical abuse
__ Natural disaster
__ Crime victim
__ Financial problems
__ Lived in foster home

Please comment on any of the above checked items (including your age when the trauma occurred and the details of the traumatic event): _____

_____
_____
_____

Therapist Notes: _____
_____
_____
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CHEMICAL USE HISTORY

Substance Type	Current Use (within the last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
PCP/LSD								
Heroin/opiates								
Methamphetamines								
Inhalants								
Other:								

Have you had withdrawal symptoms when trying to stop using any substances? __ YES __ NO. If YES, please describe the situation: _____

Have any substances created a problem for you at work or home? __ YES __ NO. If YES, please describe the situation: _____

Therapist Notes: _____
_____
_____

SOCIAL/CULTURAL HISTORY

Please check how you generally get along with other people: (check all that apply)

__ Affectionate __ Aggressive __ Avoidant __ Fight/argue often __ Follower __ Assertive
__ Friendly __ Leader __ Outgoing __ Shy/withdrawn __ Submissive

Describe special areas of interest or hobbies (i.e. art, books, crafts, physical fitness, etc.)

Activity	How often now?	How often in the past?

Please describe your strengths, skills and talents: _____
_____

To which cultural or ethnic group do you belong? _____

Are you experiencing any difficulties due to cultural or ethnic issues? If yes, please describe: _____
_____

Therapist Notes: _____
_____
_____
_____

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How important are spiritual matters to you? __ Not at all __ Little __ Somewhat __ Very much

Are you affiliated with a particular spiritual or religious group? __ YES __ NO

If yes, please describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? __ YES __ NO

MEDICAL INFORMATION

Current Physician: _____ Phone: _____

Physician's Address: _____

When was your most recent complete physical examination? _____

Have you suffered from any of the following medical conditions during your lifetime?

__ A serious accident	__ Surgery	__ Allergies
__ A head injury	__ Meningitis	__ Hospitalizations
__ High fevers	__ Hearing problems	__ Headaches
__ Vision problems	__ Asthma	__ Loss of consciousness
__ Ear infections	__ High blood pressure	__ Pregnancy/miscarriage
__ Stomach aches	__ Diabetes	__ Speech/language problems
__ Abortion	__ Chronic pain	__ A sexually transmitted disease
__ Cancer	__ Heart problems	__ Thyroid problems
__ Seizures	__ Other: _____	__ Other: _____

Please describe any checked items noting your age at the time of onset: _____
_____

List any current health concerns: _____
_____

Current medications: __ None

Medication	Dosage	Date First Prescribed	Prescribed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter medications*: __ None (*includes vitamins, herbal remedies, etc.) _____
_____

Allergies and/or adverse reactions to medications: __ None (If yes, please list): _____
_____

Therapist Notes: _____
_____
_____
_____