ADULT INFORMATION FORM

Today's Date _____

Client's Name _____

B.D. _____ Gender Identity: ☐ M ☐ F ☐ Nonbianary Other _____

Sex Assigned at Birth (If Different) ☐ M ☐ F ☐ Nonbianary

Marital Status _____

Partner's Name (if being seen as a couple) _____

B.D. _____ Gender: : ☐ M ☐ F ☐ Nonbianary Marital Status: _____

Address _____ _____ _____ _____
(Street) (City) (State) (Zip)

Telephone _____ _____ _____
Preferred Phone Secondary Phone (work)

Email _____

May we leave messages for you at home? ☐ YES ☐ NO At work? ☐ YES ☐ NO

Education: Self _____ Partner _____

Occupation: Self _____ Partner _____

Client's Employer _____

Emergency Contact _____ Phone _____

PRESENTING PROBLEMS

Describe the problem that brought you here today:

Check any of the symptoms you are having

Depression	☐	Feeling Hopeless	☐
Extreme Sadness	☐	Feeling Tearful	☐
Trouble Concentrating	☐	Change in Sleeping Habits	☐
Memory Problems	☐	Lack of Energy	☐
Change in Eating Habits	☐	Weight Changes	☐
Feelings of Extreme Happiness	☐	Change in Sexual Interest/Function	☐
Trouble Performing Your Job	☐	Feeling Stressed	☐
Not Enjoying Usual Activities	☐	Problems Getting Along With Others	☐
Self-Esteem Problems	☐	Easily Irritated	☐
Perfectionism	☐	Feeling Guilty	☐
Obsessions or Compulsions	☐	Feeling Nervous	☐
Feeling Fearful	☐	Sudden Feelings of Panic	☐
Physical Complaints of Pain	☐	Muscle Tension	☐
Problems With Anger	☐	Acting Violently	☐
Thoughts of Hurting or Killing Self	☐	Thoughts of Hurting or Killing Others	☐

Comments:

HAVE YOU EVER BEEN IN COUNSELING BEFORE? ☐ YES ☐ NO

If you have been in counseling before, please describe it below starting with the most recent.

1. Name of Counselor _____
   Dates Seen _____
   Explain What Happened

2. Name of Counselor _____

Dates Seen _____

Explain What Happened _____

MEDICAL INFORMATION

Have you seen a doctor within the past year? ☐ YES ☐ NO

If yes, what was the reason?

Who is your doctor? _____ Phone: _____

Are you taking any kind of medicine (prescription or over-the-counter)? ☐ YES ☐ NO

Please list any medicines you are taking:

Do you have allergies to anything? ☐ YES ☐ NO

Please describe any allergy problems you may have:

SUBSTANCE USE HISTORY

Do you use/have you used tobacco (any form)?	☐ Currently	☐ Past	☐ Never
Do you use/have you used alcohol?	☐ Currently	☐ Past	☐ Never
Do you use/have you used caffeine (any form)?	☐ Currently	☐ Past	☐ Never
Do you use/have you used recreational drugs?	☐ Currently	☐ Past	☐ Never