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Adult Background Form

EXCEPT IN CASES OF CHILD ABUSE OR IMMEDIATE DANGER TO YOURSELF OR OTHERS, ALL INFORMATION YOU PROVIDE WILL BE KEPT STRICTLY CONFIDENTIAL AND RELEASED ONLY IN ACCORDANCE WITH PROFESSIONAL ETHICS AND APPLICABLE LAW.

PERSONAL INFORMATION

Name: _____ Date:_____

Address:_____

Phone: (Mobile)_____ (Work)_____ (Home)_____

Date of Birth:_____ Age:_____ Gender:_____

Email Address:_____

Whom can I thank for referring you?_____

Occupation:_____

Current employment: _____

High School graduate: Yes No GED College graduate: Yes No

If Yes: Degree(s) or number of credits:_____

Field of study:_____

Occupational training (please explain):_____

_____

Military service:_____

Recreation (list some usual activities): _____

_____

_____

_____

Ethnic Background: _____Religious Affiliation:_____

Present Marital Status: ____Single ____ Living together ____ Engaged____ Married ____

Separated ____ Divorced ____ Remarried ____ Widowed

Spouse/Partner's Name:_____

Spouse/Partner's Occupation:_____

Spouse/Partner's Religious Affiliation:_____

Number of years married/living together:_____

Were there any previous marriages for either spouse:_____ If yes, please expand:
_____
_____

WHO IS LIVING IN YOUR RESIDENCE?

Name:	Age:	Relationship:

CHILDREN NOT LIVING AT HOME:

Name:	**Age:**

WHY YOU'RE HERE:

What can I do to help you? _____
_____
_____
_____
_____

On a scale of 1 (mild) to 5 (severe), how would you rate your current problem? _____

How long has this been a problem?_____

How have you tried to address this problem in the past? _____
_____
_____

Prior therapy: Yes No Name of clinician:_____

If yes, what was the duration? _____

Was your prior therapy helpful/effective?_____

MEDICAL HISTORY

Primary Care Physician's Name: _____Phone:_____

Do you or anyone else in your family have known medical problems, either current or past? If yes, please describe:_____
_____
_____

Are there any health related issues you think your therapist should know about?
_____
_____

Are you currently taking any medications? ____If yes, please list,
Medication(s):_____
Dosage(s):_____
Medicating Physician or Psychiatrist:_____ Phone:_____

Please list any hospitalizations:_____
_____
_____

What is the state of you general health?_____
_____

FAMILY HISTORY:

Your Family of Origin

Please provide data on your mother, father, siblings, and any step or half-family members:

Name and relationship	Age	Health Status	Occupation	Where Resides	Frequency of Contact
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Have you ever been separated from family members for a prolonged period? No Yes

Were there any separations from your family or either parent when you were a child (e.g., mother hospitalized)? No Yes

If yes, please explain: _____

_____

Is there any history (diagnosed or undiagnosed) of mental, emotional, or psychiatric problems in your family (e.g., anxiety, OCD, depression, ADHD, mood disorders, bipolar disorder, schizophrenia, substance abuse, or neurological problems)? No Yes

If yes, please explain_____

Have there been any deaths in the immediate family? No Yes

If yes, please list by name and relationship and identify when these occurred.

Has anyone in your family or your partner's family ever attempted suicide? No Yes

If yes, please explain _____

Has anyone in your family ever expressed concern about another family member's use of alcohol or drugs? No Yes

If yes, please Explain. _____

Do you regularly: (if so, how much or how often?)

Drink:_____ Smoke:_____

Use prescribed or non-prescribed drugs?_____

If you do, does your habit hurt your relationships with others?_____

Does it hurt your job?_____

Is it difficult to stop or control the amount you take?_____

Has anyone ever expressed concern about the ways in which anger is managed in your family? No Yes

If yes, please explain or give example (s).

Has anyone in the family ever had conflicts that resulted in physical confrontation? For example: pushing, shoving, hitting, punching. No Yes

If yes, please explain:

_____
_____
_____
_____

Is there any history of violence, verbal or sexual abuse in your family?_____

In case of an emergency whom can we notify?
Name:_____ Relationship:_____
Phone: (Home)_____ (Work) _____

Symptoms and Behaviors Checklist

Please answer every question, even if the response is "no." Indicate the severity of the symptom, if known, for the past year.

SYMPTOM	SEVERITY			
	NO	MILD	MODERATE	SEVERE
Depression				
Tearfulness				
Feeling Lonely				
Feeling Sad				
Withdrawn				
Spending more time alone				
Moody				
Avoiding friends				
Concerned about injury/bodily harm				
Eating more				
Eating less				
Weight change				
More exercise				
Less exercise				
Decreased interest in sex				
Decreased interest in usual activities				
Tired				
Sleeping more				
Sleeping less				
Waking during the night				
Waking early in the morning				
Sleepwalking				
Nightmares/bad dreams				
Headaches				
Careless about dress/hygiene				
Having trouble concentrating				
Confused				
Distractible				
Impulsive				
Disorganized				

SYMPTOM	SEVERITY			
	NO	MILD	MODERATE	SEVERE
Hearing things others don't hear				
Seeing things others don't see				
Trouble following directions				
Perfectionistic/Overly Rigid				
Anxious				
Worrying				
Feeling panicky				
Obsessive/ritualistic behaviors				
Critical of others				
Have few friends				
Low self-esteem				
Disappointed in appearance				
Disappointed in achievements				
Disappointed in social life				
Legal problems/ever been arrested				
Problems at work				
Trouble controlling aggression				
Arguing				
Defiant				
Destroying/damaging property				
Irritable				
Angry				
Easily frustrated				
Giving away belongings				
Threats to oneself				
Wishes to be dead				
Suicidal thoughts				
Suicidal intent				
History of self-injurious behavior				
Homicidal thoughts				