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ADULT DATA FORM

Please answer all information as completely as possible. Feel free to ask for assistance if needed.

Today's Date: _________________

Client's Name: ____

Last **First** **M.I.**

Address: ____

Street **Apt. #** **City** **State** **Zip Code**

Home Phone: _________________ **Work Phone:** __________________ **Cell Phone:** ____________________

Date of Birth: _____________ **Age:** ________ **Gender: M**_____ **F**_____

Employer: _______________________ **Address:** ____

If a student, grade in school: _________ **Name of School:** ____

Are you currently on probation? No____ **Yes**____ **Retained? No**____ **Yes** ____

Marital Status (indicate all that apply and duration each, ex. 1970-1985):

Never Married__________ **Married**________ **_Remarried** _________

Divorced_________ **Separated**_________ **Widowed** _________ **Number of Marriages** ________

History of learning, emotional, or behavioral problems: Yes _____ **No** _____ **(if yes, explain)** ________________

____

History of alcohol/drug/substance abuse: Yes _____ **No**_____ **(if yes, explain)** _____________________________

____

History of family violence: Yes_____ **No**_____ **(if yes, explain)** ____

____

History of criminal activity: Yes_____ **No**_____ **(if yes, explain)** __________________________________

____

Client's Physician: _______________________ Doctor's Phone number: __________________________________

List any present medical problems or current medications: ____

____

Are your currently receiving counseling? No____ Yes ____

Mental Health Professional / Agency: ____

Name Phone Number

Has client had any previous counseling or psychiatric care? (Please circle) Yes No

If yes, please indicate when and with whom: ____

What did you find most valuable from that experience? ____

Family of Origin (including yourself)

Name	Age	Gender	Relationship to you
__________________	____	_______	______________________________
__________________	____	_______	______________________________
__________________	____	_______	______________________________
__________________	____	_______	______________________________
__________________	____	_______	______________________________
__________________	____	_______	______________________________
__________________	____	_______	______________________________

Present Family (including yourself)

Name	Age	Gender	Relationship to you
__________________	____	_______	______________________________
__________________	____	_______	______________________________
__________________	____	_______	______________________________
__________________	____	_______	______________________________
__________________	____	_______	______________________________
__________________	____	_______	______________________________
__________________	____	_______	______________________________

CLIENT'S HISTORY AND EXPERIENCES

Please check all that you have experienced. * Any that is of major concern to you currently.

	Emotional Concerns:		Suicidal thoughts		Suicide Attempts
	Emotional problems		Weight Loss		Weight gain
	Appetite change		Heard voices when no one around		Loss of energy or fatigue
	Mood swings		Anger		Feeling depressed
	Trouble sleeping		Crying Spells		Social isolation
	Poor grooming		Insomnia		Sleeping too much
	Lack of motivation		Feeling "on top of the world"		Lack of enjoyment
	Self-harm		Difficulty concentrating		Feelings of hopelessness
	Loneliness		Risky behavior		Decreased interest in hobbies
	Aggressive behavior		Difficulty having fun		
	Anxiety Symptoms:		Obsessive worrying		Irritable
	Keyed up, on edge		Physical symptoms		Phobias
	Anxiety attacks		Feelings of panic		Irrational thoughts
	Inability to control thoughts		Racing thoughts		Unable to relax
	Nervous habits (nail biting)		Social Anxiety		Feeling inferior
	Nightmares		Nervous tics		
	Health & Misc. Problems:		Headache (kind)		Nervous Stomach
	Diarrhea		Constipation		Feeling Lethargic
	Bone/Joint/Muscle		PMS		Dizziness
	Heart palpitations		Shortness of breath w/o exertion		Chest pain
	Sleep problems		Fainting spells		Tremors
	Memory problems		Hearing voices		Odd behavior
	Bingeing/purging eating		Anorexia		Hallucinations
	Lack of self-control		Compulsive behavior		Oppositional behavior
	Problems with alcohol		Problems with drugs		Blackouts
	Unable to sit still		Troubles at home		Abuse prescription medication
	Difficulties with schoolwork		Difficulties with peers		Parenting/ boundary issues
	Low self confidence		Lack of Coping skills		Difficulty communicating
	Failing grades		Overweight		Poor choices in friends
	Hearing voices		Compulsive behavior		Excessive Lying
	Procrastination		Difficulty taking responsibility		Sexual abuse/trauma
	Emotional abuse/trauma		Verbal abuse/trauma		Physical abuse/trauma
	Loss of a loved one		Illness of a loved one		Suspicious of other people
	Argumentative		Immature for age		Violent at home or school
	Drinks too much		Spouse problems		Is easily frustrated
	Legal problems		Career problems		Unorganized
	"Hypochondriac"		Pouts/ sulks		Has run away
	Stubborn		Likes being in control		Introverted
	Extroverted		Likes to try new things		Trouble keeping job
	Cautious in new situations		Neurological problems		Avoid being home
	Lack of interest in sex		Problem with pornography		Sexual problems
	Compulsive sexual behavior		Excessive use of laxatives		Lose time
	Financial problems		Feeling fat		Obsessing over weight/size

Have you ever had any surgeries? If yes, please list what procedure and when._________

____

Have you ever had any major illnesses? If yes, please list what and when. ____________

____

Have you ever been hospitalized? If yes, please list for what and when. ______________

____

Do you have any chronic illnesses? If yes, please list what and when diagnosed.

____

Have you ever experienced or witnessed any Sexual, Physical, or Emotional abuse? If yes, describe the circumstances.____

____

(Circle the number that best applies)

Family Support System (such as friends, relatives, school or religious organization)

Hardly any support 1 2 3 4 5 Considerable support

How much television do you watch each week?

2-5hrs. ----- 5-8hrs. ----- 8-12hrs. ----- 12-16hrs. ----- 16+hrs.

How many hours do you spend playing video games each week?

2-5hrs. ---- 5-8hrs. ---- 8-12hrs. ---- 12-16hrs. ---- 16+hrs.

How many hours do spend on the internet/social media (not work related) each week?

2-5hrs. ---- 5-8hrs. ---- 8-12 hrs. ---- 12-16hrs. ---- 16+hrs.

What brought you to counseling at this time? ____

____

What stressors have you had in the past year? (ex. Job loss, divorce, marriage, birth of a child, death in family, move, etc.)____

____