Adult Information and History

Referred by: _____

Client's Name: _____ Today's Date: _____

Address: _____

Age: ____ Birthdate: _____ Home Phone: _____ Cell Phone: _____

Employer/School: _____

Emergency Contact: _____ Phone: _____

Phone voice messages Yes No; Text messages Yes No _____

Insurance Information

Insured's ID Number: _____

Insured's Policy, Group, or FECA Number: _____

Insured's Name: _____ Insured's Birthdate: _____

Insured's Address: ___ Same as above or _____

Employer's Name: _____

Insurance Plan Name or Program Name: _____

Is there another health benefit plan? ___ No ___ Yes

I authorize the release of any medical or other information necessary to process this claim with my insurance company.

___ Yes ___ No Signature: _____

I authorize my insurance carrier to directly pay my practitioner.

___ Yes ___ No Signature: _____

Partner's Name: NA _____ Birthdate: _____

Address: __ Same as above or _____

Phone: _____ Employer: _____

Marital Status: Mar. Div. Sgl. Sep. Years _____ Number of previous marriages: Self: _____ Partner: _____

Number of children: Self & Partner: _____ Self: _____ Partner: _____

Adult Information and History

Children and others living in household:

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Name: _____ Age: _____ Relationship _____

Previous Psychotherapy: Yes No With whom? _____

Psychiatric Hospitalizations: None _____

Physician's Name: _____ Phone: _____

Currently under medical care? Yes No _____

Current medications: None _____

Major accidents, illnesses, injuries: None _____

Trauma: None _____

Rape/Molest: None _____

Headaches	Trouble Concentrating	Heart palp/Panic	Appetite changes	School/work challenges
Blackouts	Poor anger control	Angry Outbursts	Trouble sleeping	Challenges at home
Apathy	Frequent nightmares	Poor self image	Memory problems	Fearful or shy
Lack of joy	Tension & Anxiety	Frequently tired	Depression	
Low energy	Obsessions/compulsions	Binging/Purging	Irritability	Paranoid ideation

Self
Alcohol use: None Social _____ Binge _____
Self
Drug use: None Present _____ Past _____
Partner
Alcohol use: None Social _____ Binge _____
Partner
Drug use: None Present _____ Past _____

Significant family mental health and substance abuse history: None _____

_____

Adult Information and History

Have you ever attempted suicide? Yes No _____

Are you currently experiencing suicidal thoughts? Yes No _____

Past or present thoughts or attempts to harm others? Yes No _____ _____

Past or present legal problems? Yes No _____

When you are under stress or are unhappy, what do you do to feel better: _____

Who do you turn to for support? _____

What are your strengths and interests? _____

_____

Faith: Catholic Christian JW Mormon Jewish _____ Attends: Regularly Sometimes Non-attender _____

Prenatal, early childhood: WNL _____

Family challenges: _____

_____

_____

_____

_____

Why are you coming to counseling? _____

_____

_____

Who wants you to have counseling? Self Partner Other _____

Anything else that comes to mind that I should know: _____

_____

_____

_____