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LCSW

# Adult History Form

Name _____

Date of birth _____/_____/_____ Age_____

Gender_____

Ethnicity_____

Employment_____

Student @_____

Please provide a # that is okay to leave a confidential message
_____

Email address_____

Name of Primary Care Physician_____

Name of Psychiatrist_____

**Demographic Information:**

Marital Status: Single____ Married____ Divorced____ Separated____ Widowed____ Living Together___

If currently in relationship, for how long?_____Name of your partner_____

Number of total marriages: _____

If divorced, what year did your divorce(s) finalize?_____

**Areas of concern--please check all that apply:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ____ | Self-esteem Issues | ____ | Health Issues | ____ | Depression or Sadness | ____ | Low Ambition or Motivation | ____ | Grief/Loss |
| ____ | Marital/Partner Issues | ____ | Work | ____ | Poor Sleeping | ____ | Thoughts of Suicide | ____ | Stress |
| ____ | Family Relationships | ____ | Age/Stage of Life struggles | ____ | Over/Under Eating | ____ | Nervous/Fearful | ____ | Alcohol/Drugs |
| ____ | Parenting Issues | ____ | Finances | ____ | Changes in Appetite | ____ | Anger or Irritability | ____ | Traumatic event(s) |
| ____ | Social Relationships | ____ | Low Energy/Fatigue | ____ | Poor Concentration | ____ | Anxiety/Panic | ____ | Sexual Problems |

Any other area of concern not listed above? _____

_____

_____

_____

How long have these difficulties been a concern?

_____

_____

How do these difficulties affect you and/or your family?

_____

_____

Are you currently receiving help for these difficulties anywhere else? Where? Is it helpful?

_____

_____

What do you hope to accomplish by participating in counseling? How will you know if you are making progress?

_____

_____

Have you or anyone in your family received counseling in the past? When? Was it for related or different difficulties? Was it helpful?

_____

_____

## Home/Family Information:

Please list all people who currently live with you.

| Name | Age | Relationship to you |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Do you have any children who do not live with you? _____ If so, please provide name, age and where he/she resides:

Are any of your children from a relationship other than your current one? _____

Is there anyone not present today that you would like included in future counseling sessions?

## Health Information:

Do you have any general medical conditions or health problems? If so, are you receiving treatment?

Please list any medications you are currently taking.

Have you ever been hospitalized for psychiatric treatment? If so, when and where were you hospitalized?

Please list any immediate or extended family members who have suffered with mental illness or substance abuse.

Have you ever attempted suicide? If yes, please provide details.

Have you ever self-harmed? If yes, when was the last time.

Do you currently drink alcohol? Approximately how many drinks per week? Stop Date (if applicable)?

Do you currently use recreational drugs? What types? How often? Stop Date (if applicable)?

Have you ever been concerned about your use of alcohol or drugs?

Has someone else ever expressed concern about your alcohol or drug use?

## Legal Information:

Are you currently involved in any civil or criminal legal proceedings?

Have you been involved in any criminal legal proceedings in the past?

## Social, Spiritual and Cultural Information:

Who are your primary supports in life?

Is there any information you would like to share regarding your cultural background?

Is there any information you would like to share regarding your spiritual/religious beliefs and practices or any other significant aspects of your life?