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Adult Biographical Information and Symptom Description

Please fill this form out as completely as possible. It will help me in our work together. If you feel uncomfortable answering a question, that's ok. Just write "Do not care to answer" in the space provided.

Date:_____

Name:_____
Last First Middle

Address:_____
Street City State Zip

Phone Number:_____ Email: _____

Is it ok to leave confidential/private messages at the phone number provided? Yes / No

Date of Birth: _____ Age:_____ Gender: _____

Ethnicity:_____

Emergency Contact Information:

Name:_____ Phone :_____

Who referred you?:_____

Occupation:_____

Marital Status: Single Married Partnered Divorced Widowed

Name of others who may be involved in treatment:

Medical Doctor (s): *Name and phone number.*

Medical History: *Please tell me about any major medical conditions, surgeries, accidents, or illnesses. Also note any allergies here.*

Date of last physical exam:_____

Please check applicable boxes regarding your medical history:

___ Heart Disease	___ Asthma	___Diabetes	___Thyroid
___ Arthritis	___ Cancer	___ Stroke	___ Ulcers
___ Head Injury	___ Hepatitis	___ Blindness	___ Deafness
___ Physical Disability	___ Anemia	___ Seizures	___ Hypertension

___ Currently Pregnant (Due Date) _____

List ***all*** medications you are currently taking. Include dosages and reason for taking.

Family Medical History: *Please list any illness that runs in the family.*

Have you ever, or are you now, using street drugs? Yes / No

Type / Frequency: _____

Date of Last Use: _____

How much and what type of alcohol do you consume on a daily basis?

Have you ever tried to hurt yourself or attempted suicide? Have you ever thought about suicide? *If yes, please explain.*

Have you ever tried to hurt someone else or attempted homicide? *If yes, please explain.*

Please describe your legal / criminal history.

Are you presently involved in any current or pending civil or criminal litigations, lawsuits, or divorce and custody disputes? *If yes, please explain.*

Support Network: *Please describe your support system, including friends, community activities, and spiritual affiliations.*

Psychotherapy history: *Have you ever been, or are you currently, involved in therapy? If yes, please specify provider name, duration of treatment, and whether it was helpful.*

What is the major reason for seeking services at this time?

Please place a check next to current concerns / symptoms.

___ Headache	___ Dizziness	___ Nightmares	___ Weight Change
___ Bowel trouble	___ Blurred vision	___ Binge eating	___ Muscle aches
___ Feels worthless	___ Feels tense	___ Grief / Loss	___ Can't keep jobs
___ Stomach trouble	___ Sleep Problems	___ Panicky	___ Angry
___ Distrusts others	___ Always tired	___ Lacks motivation	___Depressed
___ Cries often	___ Financial Issues	___ Self-harm	___ Anxious
___ Flashbacks	___ Withdrawn / Isolated	___ Strange experiences / thoughts	
___ Loss of interest	___ Sexual problems	___ Can't make or keep friends	
___ Fears	___ Memory Problems	___ Excessive checking, washing, etc	
___ Family Conflict	___ Concentration Issues	___ Intrusive thoughts or impulses	
___ Stressed	___ Adjustment difficulty	___ Hears/Sees/Smells things others can't	

How long have these things been bothering you?

What are your goals for therapy?