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Adult History Form

Today's Date: _____

Client Name: _____

Date of Birth: _____ Age: _____ Ethnicity:_____

Gender: ___Male ___Female ___Other (describe): _____

Address: _____

City: _____ State: _____ Zip:_____

Phone Numbers:	**Okay to Call**	**Okay to Leave Message**
Cell: _____	Y / N	Y / N
Home: _____	Y / N	Y / N
Work: _____	Y / N	Y / N

Email: _____ Okay to send email: Y / N

Emergency Contact Name/Phone Number: _____

Religion (optional): _____

Highest Grade Completed: _____

High School/Colleges Attended: _____

Reason for Seeking Therapy:

_____

_____

_____

_____

Please check all concerns that you have experienced over the last 30 days:

- □ Feelings of Depression
- □ Mood Swings
- □ High Anxiety
- □ Panic Symptoms
- □ Frequent Worry
- □ Excessive Stress
- □ School or Work-Related Concerns
- □ Social Withdrawal
- □ Low Motivation/Energy
- □ Irritability
- □ Thoughts of Suicide
- □ Racing Thoughts
- □ Compulsive Thoughts or Behaviors
- □ Hearing Voices or Seeing Visions
- □ Feelings of Paranoia
- □ Risky Behaviors, please specify: _____
- □ Memory Problems
- □ Excessive Energy
- □ Abuse or Trauma
- □ Sexual Assault
- □ Violence with Intimate Partner
- □ Self-Harm
- □ Blackouts
- □ Anger
- □ Excessive Drinking or Drug Use
- □ Difficulty with Concentration
- □ Difficulty with Attention
- □ Distractibility
- □ Hyperactivity
- □ Sleep Problems
- □ Poor Appetite
- □ Relationship Problems, specify with whom: _____

How often do you drink alcohol?:_____ Typical Amount: _____

Do you use Narcotics or other illicit drugs: Yes / No If Yes, Please describe type and amount:

_____

Please describe any current health concerns:

_____

_____

_____

Please list all medications you are currently taking:

Name of Medication	Dose	When Started	Prescribed By

Have you previously seen a mental health provider? Y / N

Have you ever been psychiatrically hospitalized? Y / N

Have you ever received treatment for substance use/abuse? Y / N

If Yes, please list:

Name	Dates Seen	Reason	Helpful Y / N

Marital Status (please circle): Single Married Partnered Other: _____

Please list all members of your current household and their relationship to you:

_____

_____

_____

_____

Do You Work? Y / N

Current Occupation: _____

Current Place of Employment: _____

Number of Years with this Employer: _____

Previous Employer if less than 2 years: _____

Have you ever served in the military? Y / N

If yes, Branch of Service and Positions Held:

_____

Date of Discharge: _____ Honorable / Dishonorable

Please list any specific questions or concerns you would like addressed during your first visit:

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this form!

_____ _____

Patient Signature Date

_____ _____

Angela C. Stanley, Psy.D. Date