

ADULT INFORMATION SHEET

Date ____/____/____ Referred by: _____

CLIENT INFORMATION

Name: _____ Age: _____ D.O.B. ____/____/____
 Address: _____ Apt#: _____
 City: _____ State: _____ Zip Code: _____
 Cell Phone: _____ Home Phone: _____ Other: _____
 Occupation: _____ Place of employment: _____

PRESENTING ISSUE

Please describe what has brought you here today: _____

TELL US ABOUT YOUR CURRENT SYMPTOMS

(check all that apply and rate the intensity of each symptom checked)

- None = Symptoms not present at this time
- Mild = Impacts quality of life, but no significant impairment of day-to day functioning
- Moderate = Significant impact on quality of life and/or day to day functioning
- Severe = Profound impact on quality of life and/or day to day functioning

Symptom	None	Mild	Moderate	Severe
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of Guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Pleasure or interest in hobbies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Symptom	None	Mild	Moderate	Severe
Irritability/Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of Worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased Crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurring thoughts/images	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of Panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory impairments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disorganized thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explain: _____

MARITAL STATUS

- Present Marital Status :** Never married Engaged Married Separated Divorced
- Divorced and remarried Widowed Widowed and remarried Number of marriages: _____
- Partner

* Your assessor will ask you more questions about your family history, which may include some questions related to past or current issues of abuse or neglect.

Social Relationships/Activities

Who do you include in your social support?

EMPLOYMENT HISTORY

Currently: Full-time Part-time Temporary Retired Laid-off Disabled
 Student Other: _____

	<u>Employer</u>	<u>Dates</u>	<u>Title</u>	<u>Reason you left the job</u>
1	_____	_____	_____	_____
2	_____	_____	_____	_____

EDUCATION

Current Student? No Yes, Where? _____

Status: Graduate Bachelors Associates Certificate

School and Major _____

Highest level of education completed: _____

MILITARY

Military experience? No Yes Combat experience? No Yes

If so, where? _____

Branch of Military: Army Navy Air Force Marines Coast Guard

Status: Active Guard/Active Guards Reserve/Active Reserve Discharge

Date of Discharge: _____ Type of Discharge: _____

Years of Service: _____ Rank at Discharge: _____

MEDICAL HISTORY

Describe your health status: Excellent Good Fair Poor

List any current health conditions or disabilities you have (i.e., high blood pressure, diabetes, etc): _____

Other past conditions or surgeries: _____

List any prescription drugs you are currently taking for your physical or mental health:

Drug's name	Dosage (mg/daily)	Dates taken	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Primary Care Physician Information: Physicians' Name: _____

Address _____ City _____ Zip Code _____ Phone Number _____

COUNSELING/MENTAL HEALTH

** Your safety is our highest priority. Your therapist will ask questions to assess if your mental health issues pose a risk to your safety, such as thoughts of hurting yourself or of suicide.*

Have you ever received counseling before? No Yes If so, why? _____

Are you currently seeing another counselor and/or Psychiatrist or Psychologist? No Yes
 If yes, who? _____ Counselor Psychologist Psychiatrist

Address _____ City _____ Zip _____ Phone _____
 With whom? _____ When? _____
 Do we have permission to contact this individual and request information? No Yes

Have you ever been diagnosed with a mental disorder? No Yes If so, what was that diagnosis (specify): _____

Have you ever been hospitalized for mental health reasons? No Yes If so, explain. _____

LEGAL

Are you currently involved in any active cases (traffic, civil, criminal)? No Yes
 If yes, please describe and include the court and pending hearing dates: _____

Are you currently on probation or parole? No Yes

If you checked "Yes" above, please provide the following information:

Past/ Currents Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____

OTHER INFORMATION

Note your personal Strengths: _____

What do you want to work on in counseling?

1. _____

2. _____

3. _____

4. _____

Anything else you would like your counselor to know:

Client Signature

Date

Provider Signature

Date