Youth For Tomorrow
Outpatient Services

14000 Crown Court, Ste. 101
Woodbridge, VA 22193
Phone # 703-396-7215
Fax # 571-285-5686

9720 Capital Court, Ste. 302
Manassas, VA 20110
Phone # 703-396-8618
Fax # 571-364-8913

7130 Heritage Village Plz, Ste. 102
Gainesville, VA 20155
Phone # 571-921-4812
Fax # 703-743-1688

6800 Backlick Road, Ste. 300
Springfield, VA 22150
Phone # 703-310-7449
Fax # 866-295-9344.

19451 Deerfield Ave, Ste. 101
Leesburg, Virginia 20176
Phone # 571-921-4812
Fax # 703-743-1688

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	☐	☐	☐	☐
Appetite Changes	☐	☐	☐	☐
Sleeping changes	☐	☐	☐	☐
Feelings of Guilt	☐	☐	☐	☐
Fatigue/low energy	☐	☐	☐	☐
Loss of Pleasure or interest in hobbies	☐	☐	☐	☐
Weight loss/gain	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐

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

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?

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EMPLOYMENT HISTORY

Currently: ☐ Full-time ☐ Part-time ☐ Temporary ☐ Retired ☐ Laid-off ☐ Disabled

☐ Student ☐ Other: _____

	Employer	**Dates**	**Title**	**Reason you left the job**
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 currents health conditions or disabilities you have (i.e., high blood pressure, diabetes, etc):

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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

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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