

**19415 Deerfield Ave, Ste. 101 Lansdowne, Virginia 20176**  
**Phone # 703-659-1433 / Fax # 703-723-7222**

**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"/>

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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?

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**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):

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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:

<b>Past/ Currents Charges</b>	<b>Date</b>	<b>Where (city)</b>	<b>Results</b>
_____	_____	_____	_____
_____	_____	_____	_____

**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:

Do not upload. For assessment only.