ADULT INFORMATION FORM

Name_____Date of first Appt._____
Date of Birth_____Age_____Sex_____Married?_____
Years Married or with Partner_____

FAMILY MEDICAL & SOCIAL HISTORY:

Medications currently taking:
1)_____Dosage/Freq._____Start Date_____Purpose_____
2)_____Dosage/Freq._____Start Date_____Purpose_____
3)_____Dosage/Freq._____Start Date_____Purpose_____
4)_____Dosage/Freq._____Start Date_____Purpose_____
Prescribed by (put med # next to Dr. if med's are Rx by diff. M.D's) _____
_____
_____
Name of Primary Care Physician:_____
His/Her Address & Ph. Number:_____
Name of Psychiatrist _____
His/Her Address & Ph. Number:_____
_____
Many managed care companies require that we interact with the client's psychiatrist or PCP to coordinate care. Do you give us that consent to discuss your care with the above named doctors?
Yes _____ or No _____Please sign here for either answer_____
Date of last Medical Evaluation: _____ Date of next appointment_____

Have you ever been admitted to an Inpatient or Intensive Outpatient psychiatric program?
YES NO Medical hospital admission(s)? YES NO Please list all below:

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs: YES NO If no, have you used previously? YES NO
If yes, when did you stop? _____
If yes, please list:

Type of Drug	How Much	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol: YES NO If no, have you drank previously: YES NO
If yes, when did you stop? _____

If yes, please list:

Type of Alcohol	How Much	How Often
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments and other health problems you experience: _____
_____
_____
_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____
_____
_____

Do you have any close relative (father, mother, brother, sister) who have experienced depression or other emotional problems? Please list: _____
_____
_____

SCHOOL & FAMILY HISTORY:
Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? YES NO If yes, please explain: _____
_____
What was the last year of school you completed?_____ If you did not complete high school, please explain why_____
_____
What school are you attending or last attend or graduate from?
School_____Year(s)_____

Currently attending above school? Yes_____ No _____

How would you describe your current emotional support network? _____
_____
_____

Please check the information that applies to your parents:
Are they biological or adoptive parents? _____

MOTHER _____living
_____deceased
_____married
_____divorced
_____remarried _____#of times

FATHER _____living
_____deceased
_____married
_____ divorced
_____remarried _____
(#of times)

Do you consider someone else (stepparent, grandparent, etc) to be one or both of your "real" parents? If so, who_____

Where do your parents live: Mother_____
Father_____
Describe your relationship with your mother while growing up:_____
_____
currently:_____
_____
Describe your relationship with your father while growing up:_____
_____
currently:_____
_____
_____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (Natural, step, half, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems that occurred while growing up relating to: alcohol/drug abuse, sexual/physical/emotional abuse: _____
_____
_____
_____

MARITAL HISTORY: Current marital status: _____Single/never married _____Married/Life Partner?_____Separated, When? _____ / _____ Divorced, When?_____ _____Widowed, When?_____ / _____Living with someone. If currently married, when were you married?_____If living with someone, how long have you lived together?_____How many times have you been married?_____.

Please list your children:

Name	Age	Relationship(natural/step)	Lives with

Others living in the home with you:

NAME	RELATIONSHIP	AGE	GRADE/OCCUPATION

MENTAL STATUS: Please check any of the following that describe how you have been feeling or acting in the last two to six months or related to the reason you are here:
____sad/depressed____anxious _____panic ____angry ____irritable ____resentful ____worthless ____tearful ____jealous ____hopeless _____helpless ____loss of sexual interest _____guilty _____ashamed ____loss of interest in activities normally interesting or fun ____low energy ____extreme mood fluctuations (discrete periods of euphoria & high energy followed by periods of deep depression & isolation) ___aggressive ____thoughts of death ____loss of concentration ____phobia(s) of:_____
___obsessive thinking re: _____
_____compulsive behaviors:_____
_____recurring intrusive thoughts or images_____ nightmares _____frightened _____ hyper-vigilance _____avoidance of people, places, situations or conversations reminding you of a distressing event?
Have you or anyone who cares about you ever had any concerns about possibility that you could have bi-polar disorder? _____
Have you experienced or been exposed to a traumatic event in recent years? Yes____ No _____
If Yes, brief description: _____
_____
Describe any other feelings you have had or elaborate on any checked from above: _____
_____
_____
Have you had any change in sleeping habits? YES NO Describe _____
_____
Have you had any change in your appetite? YES NO Describe _____
Has there been weight loss___ or gain____? How much?_____In what time span?_____
Have you ever considered suicide in connection to your **current** problems? YES NO
If so, please give a brief description with dates:_____
_____
Have you ever **considered** suicide in the **past**? YES NO
Have you **attempted** suicide recently or in the past YES NO If so, please give a brief description with dates:_____

Have you had any homicidal thoughts recently or concerning your current problem?
YES NO If yes, please explain_____

LEVEL OF FUNCTIONING: List or describe any current impediments or problems in daily behavioral, psychological, social or occupational functioning, i.e. isolation from friends/family, significant difficulty getting to work or making self do daily tasks, poor concentration or impaired memory, severe financial strain, recent divorce or problems with supervisor, etc.

THOUGHTS: Please check any of the following that apply to you.

_____I sometimes hear voices even though no one nearby is talking to me
_____I sometimes feel that forces outside of me control me
_____I sometimes feel that other people control my thoughts
_____I sometimes have the same thought over and over and cannot control it.
_____I sometimes feel that someone is out to hurt me or do something against me.
_____I am sometimes unable to control my behavior; Please explain_____

Is there any other information regarding you or your family you would like to share with your therapist that is not covered on this form, or use this space to complete earlier responses.

Thank you!