ADULT INFORMATION

General Information

Client Name _____ Date _____

Date of Birth _____ Gender: _____

Emergency Contact Name _____

Contact Phone: Cell _____Work _____Home _____

Employer_____ Occupation_____

Marital Status:

[ ] Single [ ] Married [ ] Partnership [ ] Divorced [ ] Separated [ ] Widowed

Spouse/Partner Name (if applicable):_____

Please list any children you have (gender and age):

_____

_____

_____

_____

Education History:

High School graduate? [ ] Yes [ ] No [ ] GED [ ] N/A

College graduate? [ ] Associates [ ] Bachelors [ ] Masters [ ] Ph.D

Other: _____

Military Service:

Branch:_____ When? _____ Type of Discharge? _____

Health Information

Primary Health Care Provider Name

_____

Address_____

City/State/Zip _____

Phone _____ Fax _____

ADULT INFORMATION

Height _____ Weight_____

Primary Health Concern:_____

[ ] Mild [ ] Moderate [ ] Disabling [ ] Constant [ ] Intermittent

[ ] Symptoms increase w/activity [ ] Symptoms decrease w/activity

[ ] Getting worse [ ] Getting better [ ] No change

Treatment Received:

_____

_____

_____

_____

Secondary Health Concern:_____

[ ] Mild [ ] Moderate [ ] Disabling [ ] Constant [ ] Intermittent

[ ] Symptoms increase w/activity [ ] Symptoms decrease w/activity

[ ] Getting worse [ ] Getting better [ ] No change

Treatment Received:

_____

_____

_____

_____

List all other conditions currently monitored by a Health Care Provider:

_____

_____

_____

_____

ADULT INFORMATION

List & include dates & treatments:

Major Surgeries

_____

_____

_____

_____

Accidents (physical-psychological)

_____

_____

_____

_____

Major Illnesses

_____

_____

_____

_____

Medications:

In the table below, please list any medications, you are currently taking.

Medication	Prescribed For	Dosage	Frequency	Dates/Duration
E.g. Wellbutrin	depression	100mg	2X/day	2018/current

ADULT INFORMATION

Nutritional Supplements/Herbs/Minerals:

In the table below, please list any supplements, including vitamins, minerals, herbs, amino acids, and hormones you are currently taking or that you have taken in the past.

Supplement	Dosage	Frequency	Dates/Duration
E.g., Vitamin C	500 mg	2/day	2014 / current

Use of Non-Pharmaceutical Substances:

Current	Past		Times per week / Comments
[ ]	[ ]	Tobacco	_____
[ ]	[ ]	Alcohol/drugs	_____
[ ]	[ ]	Coffee/Soda	_____
[ ]	[ ]	Other	_____

Are you a recovering addict? [ ] Yes [ ] No

History of drug/alcohol abuse? [ ] Yes [ ] No

Long term use of prescription/recreational drugs? [ ] Yes [ ] No

If yes, how often and in what form?

_____

_____

ADULT INFORMATION

History of suicidal ideation or attempts? [ ] Yes [ ] No

If yes, when and circumstances:

_____

_____

_____

History of homicidal ideation or attempts? [ ] Yes [ ] No

If yes, when and circumstances:

_____

_____

_____

History of any psychiatric inpatient treatment? [ ] Yes [ ] No

If yes, when and circumstances:

_____

_____

_____

History of outpatient treatment? [ ] Yes [ ] No

If yes, when and circumstances:

_____

_____

_____

Please circle any symptoms you have been bothered by in the past 3 months:

Appetite increase/decrease	Crying episodes	Frustration
Increase sleep	Increased sensitivity	Irritability
Energy decreased	Insomnia	Boredom
Short temper	Sadness/Down	Libido decrease
Motivation decrease	Not able to relax	Helplessness
Concentration difficulties	Muscle tension	Hopelessness
Discouragement about the future		Energy increased

Other symptoms not listed:

_____

_____

Family History

Please give age and list any medical and/or mental illness. If deceased, please list cause and age of death.

Mother:

_____

_____

_____

Father:

_____

_____

_____

Siblings:

_____

_____

_____

_____

Were your parents divorced? [ ] Yes [ ] No

If yes, how old were you when they got divorced? _____

If not raised by parents, who raised you? _____

Daily Activities

Work description _____

Work Hours and Schedule _____

Do you now or have you ever worked the night shift? [ ] Yes [ ] No

If yes, what are your hours? _____

ADULT INFORMATION

Describe activities:

Home/Family

_____

_____

_____

_____

Social/Recreational

_____

_____

_____

_____

Are there any activities currently affected negatively right now? [ ] Yes [ ] No

If yes, please explain: _____

_____

Are you able to fall asleep? [ ] Yes [ ] No

Are you able to stay asleep? [ ] Yes [ ] No

Do you exercise regularly? [ ] Yes [ ] No

If yes, please explain (type of exercise, how often):

_____

_____

How do you reduce stress?

_____

_____

_____

_____

List all significant stressors (include dates):

_____

_____

_____

_____

_____