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Adult History and Checklist of Concerns

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Contact: (please check one box for preferred number)

Home: \_\_\_\_\_  Cell: \_\_\_\_\_  Work: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Occupation: \_\_\_\_\_ Current Employer: \_\_\_\_\_

Emergency Contact Information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Marital Status:  Single/Never Married  Married  Separated  Divorced  Widowed

Please Indicate Names, Gender and Ages of Your Children, if Any:

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

**Family-of-Origin History (please answer only for the significant relatives in your life):**

Relative	Name(s)	Current Age (or age at death)	Illnesses (or cause of death, if deceased)	Highest Education	Occupation
Father					
Mother					
Stepparents					
Brothers					
Sisters					
Step-siblings					
Grandparents					
Other significant family relationships (describe):					

**Marital History:**

	Spouse's Name	Spouse's Age at Marriage	Your Age at Marriage	Your Age When Divorced/ Widowed	Spouse's Occupation
Current					
First					
Second					

**Significant Nonmarital/Romantic Relationships:**

	Name of Other Person	Person's Age When Started	Your Age When Started	Your Age When Ended	Reason for Ending
Current					
First					
Second					
Third					

**Educational History:**

	Name of School	Dates Attended
High School:	_____	_____
College:	_____	_____
Graduate School:	_____	_____

**Treatment History:**

Have you ever received psychotherapy, counseling, or drug/alcohol treatment before?

No  Yes (If Yes, please indicate):

Dates of treatment	Provider/Facility Name	Reason for treatment	Treatment helpful/effective?
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever taken medications for psychiatric or emotional difficulties?

No  Yes (If Yes, please indicate):

Dates Taken	Prescribing Physician	Medication Name	Reason for Medication	Results

Please indicate if any of the following is a current or past concern (any time in the past):

	Current Concern	Past Concern
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Suicide attempts/gestures	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient psychiatric hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Self-mutilation/self-harm	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
Drug use: prescription medications, OTC medications, street drugs	<input type="checkbox"/>	<input type="checkbox"/>
History of aggression/violence/threats toward others	<input type="checkbox"/>	<input type="checkbox"/>

If you checked any of the boxes above, please provide details:

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