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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:
