CHILD AND FAMILY COUNSELING CENTER
ADULT HISTORY FORM

IDENTIFYING INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE FORM COMPLETED: _____

REASONS FOR SEEKING TREATMENT: _____

_____

_____

DURATION OF PROBLEM: 1-3 mos. 6-12 mos. 1-2 yrs. 2-5 yrs. 5-10 yrs. 10+yrs.

CURRENT THERAPY? YES NO

If yes, please list the name of your therapist:_____

_____

ARE YOU CURRENTLY TAKING PSYCHIATRIC MEDICATION? YES NO

If yes, please give the name of your prescriber and list the medications you are taking (and dosages):

_____

_____

_____

PRIOR THERAPY? YES NO BRIEF LONG TERM REPEATED DAY TX INPATIENT

PHP IOP HELPFUL UNHELPFUL NOT SURE

NAMES OF PREVIOUS THERAPISTS (Include phone numbers if you know them):_____

_____

_____

NAMES OF PREVIOUS PSYCHIATRISTS (Include phone numbers if you know them):_____

_____

_____

FAMILY DATA

CURRENT MARITAL STATUS: NEVER MARRIED MARRIED SEPARATED DIVORCED

IN A COMMITTED RELATIONSHIP REMARRIED WIDOWED

MARITAL HISTORY

DATES MARRIED SPOUSE'S NAME

1. _____

2. _____

3. _____

4. _____

IF NOT REMARRIED:

DO YOU HAVE A SIGNIFICANT OTHER? YES NO

IF SO, FOR HOW LONG? _____

WHO LIVES IN YOUR HOME?

ADULTS: .

NAME *AGE* *RELATIONSHIP*

1. _____

2. _____

3. _____

4. _____

5. _____

CHILDREN IN THE HOME AND AGES:

1. _____ 5. _____

2. _____ 6 _____

3 _____ 7. _____

4. _____ 8. _____

YOUR OCCUPATION:_____

HOW LONG HAVE YOU BEEN IN YOUR CURRENT JOB?_____

ARE YOU A HIGH SCHOOL GRADUATE? YES NO GED

ARE YOU A COLLEGE GRADUATE? YES NO DEGREE EARNED:

FIELD OF STUDY:_____

HISTORY OF MILITARY SERVICE? YES NO

RELIGIOUS AFFILIATION?: YES NO IF YES, WHICH? _____

DO YOU HAVE CLOSE FRIENDS? NO YES

IF YES, HOW OFTEN ARE YOU IN TOUCH WITH THEM? _____

SUBSTANCE USE

DO YOU USE ALCOHOL? NO YES

IF YES, PLEASE NOTE FREQUENCY AND AMOUNT OF USE (e.g. 3 times weekly, 4-6 beers):

_____

_____

_____

DO YOU USE TOBACCO OR SMOKE CIGARETTES? NO YES DO YOU VAPE? YES NO

IF YES, HOW MUCH DO YOU SMOKE/VAPE PER DAY? _____

DO YOU USE MARIJUANA? NO YES

IF YES, PLEASE LIST IN WHAT FORM (E.G. VAPE, EDIBLES, SMOKE) AND FREQUENCY OF USE.

_____

_____

DO YOU USE OTHER DRUGS? NO YES

IF YES, PLEASE LIST DRUGS AND THE FREQUENCY OF USE.

_____

_____

_____

LEGAL HISTORY

ANY HISTORY OF LEGAL PROBLEMS (e.g. arrests or incarceration)? NO YES
IF YES, PLEASE DESCRIBE BRIEFLY:_____

_____

ARE YOU ON PROBATION? NO YES

DO YOU HAVE A COURT DATE COMING UP? NO YES

IF YES, WHAT FOR? _____

FAMILY PSYCHIATRIC AND SUBSTANCE ABUSE HISTORY

IS THERE ANY HISTORY OF VIOLENCE IN YOUR FAMILY? NO YES

IS THERE ANY HISTORY OF SUICIDE IN YOUR FAMILY? NO YES

IS THERE ANY HISTORY OF ALCOHOL OR DRUG PROBLEMS IN YOUR FAMILY? NO YES

IS THERE ANY HISTORY OF PSYCHIATRIC PROBLEMS IN YOUR FAMILY, E.G. DEPRESSION, ANXIETY, BIPOLAR DISORDER, SCHIZOPHRENIA, ADHD, AUTISM, ETC.? NO YES
IF YES, DESCRIBE:

_____

_____

_____

HAVE THERE BEEN ANY TRAUMATIC EVENTS IN YOUR LIFE? NO YES
IF YES, EXPLAIN:

_____

_____

MEDICAL/HEALTH HISTORY

NAME OF PRIMARY CARE PHYSICIAN: _____

ADDRESS/PHONE:_____

DATE OF LAST PHYSICAL:_____

RIGHT OR LEFT HANDED? RIGHT LEFT

ANY PHYSICAL OR INTELLECTUAL HANDICAPS? YES NO
IF YES, DESCRIBE:

_____

ANY CHRONIC HEALTH CONDITIONS, SUCH AS ASTHMA, HIGH BLOOD PRESSURE, HEART PROBLEMS, ETC? YES NO

IF YES, LIST: _____

_____

ANY REGULAR NON-PSYCHIATRIC MEDICATIONS? YES NO

IF YES, LIST ANY MEDICATIONS AND DOSAGES IF KNOWN:

_____

_____

_____

_____

_____

DO YOU TAKE ANY VITAMINS OR OTHER SUPPLEMENTS? YES NO
IF YES, WHICH ONES?

_____

_____

HAVE YOU EVER BEEN HOSPITALIZED FOR PHYSICAL OR EMOTIONAL PROBLEMS? NO YES
IF YES, BRIEFLY DESCRIBE WHEN AND WHY:

_____

_____

_____

ANY HISTORY OF ALLERGIES, INCLUDING ALLERGIES TO MEDICATIONS: NO YES
IF YES, DESCRIBE:

_____

_____

HAVE YOU EVER HAD A SERIOUS MEDICAL PROBLEM? NO YES (explain)
IF YES, EXPLAIN

_____

_____

_____

ANY HISTORY OF HEAD INJURIES, LOSS OF CONSCIOUSNESS, OR BLOWS TO THE HEAD? NO YES
IF YES, DESCRIBE:

_____

_____

_____

ANY SERIOUS ACCIDENTS/ILLNESSES WHICH DID NOT REQUIRE HOSPITALIZATION? NO YES
IF YES, DESCRIBE:

_____

_____

ANY PROBLEMS WITH YOUR MEMORY? NO YES
IF YES, DESCRIBE:

_____

_____

HOW MUCH EXERCISE DO YOU GET ON A DAILY BASIS?_____

_____

DO YOU EAT A WELL-BALANCED DIET? YES NO

IF NO, DESCRIBE ANY PROBLEMS WITH DIET:

_____

_____

DO ANY OF YOUR BIOLOGICAL RELATIVES HAVE A HISTORY OF HEALTH PROBLEMS, SUCH AS HIGH BLOOD PRESSURE, DIABETES, HEART DISEASE, ETC? YES NO
IF YES, DESCRIBE:

_____

_____

_____

_____

FAMILY OF ORIGIN

ARE YOU CLOSE TO MEMBERS OF YOUR FAMILY OF ORIGIN? YES NO
IF YES, WHO ARE YOU CLOSEST TO?

_____

_____

HAVE YOU HAD ANY SIGNIFICANT SEPARATIONS FROM CAREGIVERS
WHEN YOU WERE A CHILD? YES NO

IF YES, BRIEFLY EXPLAIN:

_____

_____

_____

_____

ANY HISTORY OF PHYSICAL ABUSE AS A CHILD/ADOLESCENT? YES NO

ANY HISTORY OF SEXUAL ABUSE AS A CHILD/ADOLESCENT? YES NO

ANY HISTORY OF EMOTIONAL ABUSE AS A CHILD/ADOLESCENT? YES NO

ANY CURRENT PROBLEMS WITH BEING MISTREATED OR ABUSED? YES NO

IS THERE ANY OTHER INFORMATION YOU WISH TO PROVIDE?

_____

_____

_____

_____

_____

(Updated 2-3-26)