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♥ ADULT DATA FORM ♥

Today's Date*_____________________*Please answer all information as completely as possible. Information given is strictly confidential. Feel free to ask for assistance, if needed.

Name:____ ***Gender***: M____ F____
Last First MI

Date of Birth:_______________ ***Cell***___________________ ***Email:***__________________________
Address:____
Street Apt. City State Zip

Gross Household Annual Income:
___$10,000 – 30,000 ___30,001 – 60,000 ___60,001 – 90,000 ___90,001 – 200,000 ___200,001 – up

Educational Level:
___High School/GED_____ ___College Graduate ___Ph.D. Degree ___Other
___Trade School/Some College ___Master's Degree ___JD Degree

Marital Status *(indicate all that apply and duration of each, ex. 1965-1985):*
Never married____________ Married____________ Divorced___________
Separated___________ Widowed_____________ Partnership______________
Single____________

Family in which you grew up *(Your parents and siblings; include yourself)*

Name	Age	Gender	Relationship to you	(check if yes)
__________________	_____	__________	_____________________________	Adopted?___
__________________	_____	__________	_____________________________	Adopted?___
__________________	_____	__________	_____________________________	Adopted?___
__________________	_____	__________	_____________________________	Adopted?___

Describe any history in your family regarding:

Learning, emotional, or behavioral problems - ____

Alcohol/drug abuse/eating disorder - ____

Domestic violence - ____

Criminal activity - ____

Sexual/verbal/mental abuse - ____

Family today *(significant other and/or children; include yourself)*

Name Age Gender Relationship to you

___________________ _____ __________ ________________________ Adopted?___
___________________ _____ __________ ________________________ Adopted?___
___________________ _____ __________ ________________________ Adopted?___
___________________ _____ __________ ________________________ Adopted?___

Describe any history in your family today regarding:

Learning, emotional, or behavioral problems -____

Alcohol/drug abuse/substance abuse - ____

Domestic violence - ____

Criminal activity - ____

Sexual/verbal/mental abuse - ____

** HEALTH **

Date of LAST complete physical_________________

Physical Disability: yes__ no__ If yes, explain ____
____

Chronic Illness: yes__ no__ If yes, explain____
____

List medication you are currently taking:

Diagnosis	*Medication*	*Dosage*
______________________________	________________________	_________________
______________________________	________________________	_________________
______________________________	________________________	_________________

Physician/Psychiatrist prescribing medication:____

Name *phone #*

Other treatment you have received: None___ Individual counseling:___ (dates:_____________)
Family counseling:___ (dates:_______________) Group counseling:___ (dates:_______________)
Couples Counseling:___ (dates:________________) Hospice___ (dates:________________)
Hospitalization:___ (dates:_______________) Other (explain)_______________________________

Primary Care Physician:____

Name *phone #*

♥ ***CURRENT CONCERNS*** ♥

___Adjustment to life changes (loss of job, changing jobs, divorce, moving, etc.)
___Abuse (physical, emotional, sexual)
___Disturbing memories (past abuse, neglect or other traumatic experience)

___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Feeling anxious (nervous, fearful, worried, panicky, obsessive-compulsive, lacking trust, withdrawn)
___Feeling angry or irritable, feel like hurting others
___Feeling guilty or shameful
___Feeling sadness depression or suicidal urges related to grief
___Feeling sadness depression or suicidal urges NOT related to grief
___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (runaway, stealing, repeated run-ins with the law, etc.)
___Learning/Academic difficulties
___Personal Growth (no specific problem)
___Family relationships
___Non-family relationship (roommates, friends, etc.)
___Sleep problem (nightmares, night-terror, sleeping too much or too little, etc.)
___Sexual concerns (excessive masturbation, inappropriate acting out)
___Sexual identity concern (gay, lesbian, bisexual, transsexual, transvestite)
___Speech problem (not talking, stuttering, etc.)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___Other (explain____)

* *FAMILY HISTORY/EXPERIENCES* *

Emotional Concerns: Emotional problems___ Suicidal thoughts___ Suicide attempts (#)___ Loss of energy or fatigue___ Lost weight___ Gained weight___ Appetite change___ Heard voices when no one was around___ Other (explain)_________________________________

Anxiety Symptoms (indicate all that apply): Obsessive worrying___ Keyed up, on edge___ Phobias___ Irritable___ Physical symptoms (below)___ Other____________________________

Health/Physical Problems (indicate all that apply): Headache(kind)_________ Nervous stomach___ Diarrhea___ Bone/joint/muscle___ PMS___ Dizziness___ Shortness of breath without exertion___ Heart Palpitations___ Chest pain___ Surgeries___ Major illness___ Major accident___ Disability___ Chronic illness___ Hospitalization___ Developmental delay(s)___ Sleep problem___ Bedwetting___ Serious overeating or undereating___ Neurological problems/exam___ Other__________________________

Dissociative Symptoms (Indicate all that apply): Walked in sleep___ Trance-like episodes where you lost track of time___ Large parts of childhood after age 5 you can not remember___ Memories suddenly flashback___ Periods of missing time___ Things of yours that are missing___ Things appear, but you do not know where they came from___

Trauma/Stressor (Indicate all that apply):
Child separated from parent (how long and when):_____________ ______________________________
Death of a significant person___ (name of deceased_______________________________; relationship to you___________________; date of death ________________)
Death of a pet___ Incarcerated family member___ Sexual Assault___
Victim of trauma (unusual, terrifying experience)___
Medical___ Natural Disaster___ Other____

Interpersonal Problems (Indicate all that apply): Frequent arguments___ Taken advantage of___ Temper outbursts___ Slapping, hitting, shoving, etc., other people___ Loner___
Other____

Family Atmosphere (circle the number that best describes how you view your current family, if applicable):

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Not spiritual	1	2	3	4	5	Very spiritual
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

Support System *(such as church, friends, relatives, school)*

Hardly any support 1 2 3 4 5 Considerable support

Hours spent watching TV each week: 1 3 5 7 9 12+

Hours spent using computer at home each week: 1 3 5 7 9 12+