Journeys Counseling
Phone: 563-213-5050 journeyscounselingdbq.com

ADULT INFORMATION FORM

Name_____ Date of 1st Appointment_____ Therapist _____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____ Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken:

1)_____ Dosage/Freq_____Start Date_____Purpose_____

2)_____ Dosage/Freq_____Start Date_____Purpose_____

3)_____ Dosage/Freq_____Start Date_____Purpose_____

4)_____ Dosage/Freq_____Start Date_____Purpose_____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience:_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

_____

_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

_____

_____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain: _____

_____

What was the last year of school you completed? _____ If you did not complete high school, please explain:

_____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s) _____ Year(s) _____

(2) School(s) _____ Year(s) _____

(3) School(s) _____ Year(s) _____

How would you describe your current support network? (friends, relatives, etc.): _____

_____

Please check all information which applies to your biological parents:

MOTHER	FATHER
____ living	____ living
____ deceased	____ deceased
____ married	____ married
____ divorced	____ divorced
____ remarried____# of times	____ remarried____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

_____

Where do your parents live? Mother _____

Father _____

Describe your relationship with your mother while growing up: _____

_____

Currently: _____

_____

Describe your relationship with your father while growing up: _____

_____

Currently: _____

_____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NAME: DOB: Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse: _____

_____

_____

Sexual/physical/emotional abuse: _____

_____

_____

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

____sad_____anxious_____depressed_____frightened_____guilty_____angry_____ashamed_____aggressive____resentful
____worthless____tearful_____irritable_____confused_____extreme ups/downs_____jealous_____hopeless_____helpless

Describe any other feelings you have had: _____

_____

What activities or hobbies do you participate in? _____

_____

Do you participate in regular exercise? (Circle One) YES NO Describe: _____

Describe your current working environment: _____

_____

Have you had any change in sleeping habits? (Circle One) YES NO Describe: _____

_____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain: _____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

NAME: **DOB:**

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): _____

_____

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.

_____I sometimes feel that forces outside of me control me.

_____I sometimes feel that other people control my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes feel that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior. Please explain:_____

_____

_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

_____

Please list your therapy goals:

_____

_____

_____

_____

_____

THANK YOU!

NAME: DOB: