Adult CLIENT:

Name: _____ **Sex:** M F **DOB:** _____/_____/_____Age: _____

Family and Relationship Status:

___Single ___Married/significant relationship

___Divorced/relationship dissolved ___Separated

___Widowed (Year/s_____)

Spouse/Significant other Name: _____Years together_____

List all **children** and their ages:

1

2

3

General Physical Health:

Physician: _____Date of last visit: _____

Height _____ Weight _____

Medications

Are you currently taking any **prescription medications**? __ No ___Yes, (please list):

Medications:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Medical Conditions/Diagnoses:

Educational/Occupational:

Education: (highest achieved) _____

Employment status: ___Student ___Working ___Unemployed ___Other _____

Present occupation/job: _____

Behavioral/Mental Health **Name: _____**

1) Have you previously received any type of mental health services (i.e. evaluation, psychotherapy, counseling, psychiatric services)? __ No__ Yes, if so please provide the name of the previous therapist/practitioner: _____

2) Have you ever been prescribed psychiatric medications in the past? ___No ___Yes _____

3) Do you or anyone in your family have a history of (check all that apply):

___Alcohol/Substance Abuse ___ Anxiety ___ADHD ___Depression___Domestic Violence

____Dyslexia ___Eating Disorders ___Obesity ___Obsessive Compulsive Behavior

___Schizophrenia ___Suicide Attempts

Personal Assessment:

1) How would you rate your **current physical health**?

___Poor ___ unsatisfactory ___ satisfactory ___ Good ___ Very Good

2) How would you rate your **current sleeping habits**?

___Poor ___ unsatisfactory ___ satisfactory ___ Good ___ Very Good

3) How is your **appetite**?

___Poor ___ unsatisfactory ___ satisfactory ___ Good ___ Very Good

4) How many times per week do you **exercise**? _____Type? _____

5) Do you drink **alcohol** more than once a week? ___ No ___ Yes, if so, how much? _____

6) Do you utilize recreational drugs? ____No __ Yes, if so please explain _____

7) Do you consider yourself **spiritual or religious**? ___No ____Yes _____

Personal Event History: Describe any major changes that have occurred to you or your family

In the last year: _____

In the past five years: _____

In your lifetime: _____

Name: _____

Today 's Concern: (What is your reason for seeking counseling today?):

_____

_____

Personal

1. What do you consider to be some of **your strengths**?

_____

2. What do you consider some of **your weaknesses**?

_____

3. **What would you like to accomplish** out of your time in therapy?

_____

How did you hear about my services? _____