LifeMenders
Counseling

ADULT INFORMATION FORM

Name_____ Date of 1st Appointment_____ Therapist Starr Burgess

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication and substance History:

Please indicate with an check how often you use any of the following:

	Daily	Frequently	Occasionally	Never
Appetite Suppressants	☐	☐	☐	☐
Sedatives/Tranquilizers	☐	☐	☐	☐
Sleeping Pills	☐	☐	☐	☐
Stimulants	☐	☐	☐	☐
Narcotics	☐	☐	☐	☐
Pain Killers	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐
Hallucinogens	☐	☐	☐	☐
Blood Pressure Medicine	☐	☐	☐	☐
Heart Medicine	☐	☐	☐	☐
Birth Control	☐	☐	☐	☐
Other (Please specify)	☐	☐	☐	☐

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? 12 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.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:_____

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!