ADULT CLIENT INFORMATION & HISTORY

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All information you provide here is held to the same standards of confidentiality as our therapy. Leave blank any question you would rather not answer. Please fill out this form prior to our first session.

Date: ___________ Referred By: ____________________________ May I thank them for the referral? Y / N

Client Name: ____ ☐ Male ☐ Female

Address: _______________________________________ City: _________________ Zip Code: _____________

Best phone number & time to reach you: _______________________________ May I leave a message? ______

Age: _______ Birthdate: ____/____/_____ Education Completed: __________________________________

Name(s) & age(s) of child(ren): ____

Emergency contact: _________________________ Relationship: ____________ Phone #: _______________

Employer/Occupation: ____

Employment Status: ☐Full-time ☐Part-time ☐Choose to stay at home ☐Unemployed

Are you happy at your current position? ____

Please list any work-related stressors: ____

What concerns lead you to therapy at this time? ____

____

____

What goals do you have for therapy? ____

____

____

Are you currently receiving psychiatric care or psychotherapy elsewhere? ☐Yes ☐No

If Yes, with whom? ____

Please describe any previous therapy experience: ____

____

Are you currently taking prescribed psychiatric medication (antidepressants, etc)? ☐Yes ☐No

If Yes, please list: ____

Please list medications taken in the past: ____

Have you ever been hospitalized for psychiatric reasons? ☐Yes ☐No

If yes, describe with dates: ____

Have you thought about or attempted suicide? ☐Yes ☐No

If yes, please describe: ____

HEALTH AND SOCIAL INFORMATION

Please list any persistent physical symptoms or health concerns: _________________________________

____

Current medications: ____

Primary care physician: ____________________________________ Phone #: ____________________

Are you having any problems with sleep? ____

What are your exercise habits? ____

Are you having any difficulty with appetite, weight, or eating habits? ☐Yes ☐No

If yes, describe: ____

Do you smoke or use tobacco? ☐Yes ☐No Please describe: ______________________________________

Do you drink alcohol? ☐Yes ☐No Please describe: ____

Do you use other/recreational drugs? ☐ Daily ☐ Often ☐ Rarely ☐ Never ☐ Not any more

If at all, please describe: ____

Have you ever experienced a concussion or other head injury? If yes, list date(s) and information known:

____

Current relationship status: Single | Dating | Separated | Living together | Married | Divorced | Widowed

Date of Marriage (if applicable): ______________ Date of Divorce (if applicable): ____________

If applicable, please describe the quality of your current relationship: ______________________________

____

Please describe your relationship history: ____

____

What of the following have you experienced or noticed in yourself in the ***past year***? (check all that apply)

- ☐ Chronic Pain or Illness
- ☐ Educational Problems
- ☐ Family or Parenting Conflict
- ☐ Financial Problems
- ☐ Grief/Loss
- ☐ Legal Problems
- ☐ Loneliness
- ☐ Major Life Change
- ☐ Other (specify): ___________________________
- ☐ Concentration or Memory Difficulty
- ☐ Compulsive or Impulsive Behaviors
- ☐ Restlessness
- ☐ Sexual Dysfunction
- ☐ Social Discomfort/Shyness
- ☐ Identity Confusion
- ☐ Spiritual Confusion
- ☐ Trauma or disturbing life experience

FAMILY & MENTAL HEALTH HISTORY:

Check if yes	Who?	Received treatment?
☐Depression		Y / N
☐Bipolar Disorder		Y / N
☐Anxiety Disorders		Y / N
☐Panic Attacks		Y / N
☐Schizophrenia		Y / N
☐Addiction		Y / N
☐Eating Disorders		Y / N
☐Learning Disabilities		Y / N
☐ADHD		Y / N
☐Trauma/Abuse History		Y / N
☐Suicide Attempts		Y / N

Briefly describe your relationship with your:

Mother: ____

Father: ____

Sibling(s): ____

Extended family: ____

Child(ren): ____

Do you consider yourself to be religious? __________ If yes, what is your faith? ____________________

If no, do you consider yourself to be spiritual? ____

Do you feel that your faith should be a significant part of your therapy? ☐Yes ☐No

Please describe: ____

What do you consider to be your strengths? ____

____

What do you like most about yourself? ____

____

How do you typically cope with problems in your life? ____

____

ADVERSE CHILDHOOD EXPERIENCES SCALE

These questions are based on the Adverse Childhood Experiences Study, originally by Kaiser Permanente in 1997.
See www.acestudy.org for more information.

Please circle "yes" or "no" for each question below.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often** …
   Swear at you, insult you, put you down, or humiliate you?
   Or - Act in a way that made you afraid that you might be physically hurt?
   Yes / No

2. Did a parent or other adult in the household **often or very often** …
   Push, grab, slap, or throw something at you?
   Or - Ever hit you so hard that you had marks or were injured?
   Yes / No

3. Did an adult or person at least 5 years older than you **ever** …
   Touch or fondle you or have you touch their body in a sexual way?
   Or - Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes / No

4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   Or - Your family didn't look out for each other, feel close to each other, or support each other?
   Yes / No

5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   Or - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes / No

6. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason?
   Yes / No

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   Or - **Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with something hard?
   Or - **Ever** repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes / No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes / No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes / No

10. Did a household member go to prison?
    Yes / No

Is there anything else you want me to know? ____

____

____

Client Signature ______________________________________ Date ______________

Elizabeth M. Heuertz, LPC ________________________________ Date ______________