

# Adult History Form - R

Please take your time and fill in completely.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## OCCUPATIONAL BACKGROUND

Current Occupation: \_\_\_\_\_ How long? \_\_\_\_\_

Describe any dissatisfaction or problems in your present job: \_\_\_\_\_

List previous jobs and time spent working in each one: \_\_\_\_\_

---

## EDUCATIONAL BACKGROUND

Highest grade completed: \_\_\_\_\_ College degrees obtained: \_\_\_\_\_

Describe any academic or behavior problems you had in school: \_\_\_\_\_

## FAMILY OF ORIGIN HISTORY

City of birth: \_\_\_\_\_

In what city were you raised? \_\_\_\_\_

How many times did you move prior to leaving your parent's home? \_\_\_\_\_

How many children were in your family? \_\_\_\_\_ Which one were you? \_\_\_\_\_

Who were you closest to in your family? \_\_\_\_\_ Most distant from? \_\_\_\_\_

Describe your relationship with each of your parents: \_\_\_\_\_

Problems experienced during child and teen years: \_\_\_\_\_

Describe any mental illness, substance abuse or legal problems in your family of origin: \_\_\_\_\_

---

## CURRENT FAMILY HISTORY

Marital status (check all that apply):

\_\_\_\_\_ Single, never married  
\_\_\_\_\_ Married How long? \_\_\_\_\_  
\_\_\_\_\_ Separated How long? \_\_\_\_\_  
\_\_\_\_\_ Divorced How long? \_\_\_\_\_  
\_\_\_\_\_ Widowed How long? \_\_\_\_\_

How many times have you been married? \_\_\_\_\_

## CURRENT PARTNER RELATIONSHIP HISTORY

How satisfied are you right now in your relationship?

0                      1                      2                      3                      4  
Not at all          Slightly          Moderately          Very          Extremely

How committed are you right now to enhancing your relationship?

0                      1                      2                      3                      4  
Not at all          Slightly          Moderately          Very          Extremely

Describe your relationship with your partner using the following checklist:

- |   |  |
|---|--|
| <input type="checkbox"/> Emotionally Connected              | <input type="checkbox"/> Emotionally Distant                       |
| <input type="checkbox"/> Sexual Relationship is satisfying  | <input type="checkbox"/> Sexual Relationship is not satisfying     |
| <input type="checkbox"/> We have common goals and values    | <input type="checkbox"/> We do not have common goals and values    |
| <input type="checkbox"/> We communicate well                | <input type="checkbox"/> We do not communicate well                |
| <input type="checkbox"/> We enjoy spending time together    | <input type="checkbox"/> We do not enjoy spending time together    |
| <input type="checkbox"/> We are a cohesive parental unit    | <input type="checkbox"/> We are not a cohesive parental unit       |
| <input type="checkbox"/> We solve problems/issues as a team | <input type="checkbox"/> We do not solve problems/issues as a team |

What do you like to do with your partner: \_\_\_\_\_

Describe any difficulties with family finances: \_\_\_\_\_

Describe any parenting difficulties: \_\_\_\_\_

Check all that apply and describe below:

- I have had an inappropriate outside relationship.
- I am currently having an inappropriate outside relationship.
- My partner has had an inappropriate outside relationship.
- My partner is currently having an inappropriate outside relationship.
- I am verbally abusive toward my partner.
- I am physically abusive toward my partner.
- I am sexually abusive toward my partner.
- My partner is verbally abusive toward me
- My partner is physically abusive toward me.
- My partner is sexually abusive toward me.
- My partner and I have destructive arguments.
- I am afraid of my partner.
- My partner is afraid of me.

Explain the checked items above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Check the 3 areas you want most to change in your relationship:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Emotional connectedness | <input type="checkbox"/> Conflict management | <input type="checkbox"/> Family finances |
| <input type="checkbox"/> Role satisfaction       | <input type="checkbox"/> Communication       | <input type="checkbox"/> Parenting       |
| <input type="checkbox"/> Sexual relationship     | <input type="checkbox"/> Romance & passion   | <input type="checkbox"/> Commitment      |

Please complete the following information about each of your children:

Name	Sex	Age	Residence	Describe your relationship with each child.

### PSYCHOLOGICAL HISTORY

Have you ever considered or attempted suicide? \_\_\_\_\_ Describe: \_\_\_\_\_

Describe any emotionally disturbing experiences you have had: \_\_\_\_\_

Describe what has been stressful for you in the past year: \_\_\_\_\_

Have you ever been arrested? \_\_\_\_\_ If yes, what were the charges? \_\_\_\_\_

Have you ever been physically abused? \_\_\_\_\_ If yes, at what ages: \_\_\_\_\_

Have you ever been sexually abused? \_\_\_\_\_ If yes, at what ages: \_\_\_\_\_

### SYMPTOM CHECKLIST

1. Please check each symptom experienced within the past *two months*.
2. Then circle your worst symptoms (six to eight).

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Depressed mood       | <input type="checkbox"/> Obsessive thoughts                | <input type="checkbox"/> Hears voices                                 |
| <input type="checkbox"/> Feel worthless       | <input type="checkbox"/> Compulsive behavior               | <input type="checkbox"/> Sees things that are not there               |
| <input type="checkbox"/> Hopeless or helpless | <input type="checkbox"/> Nightmares                        | <input type="checkbox"/> Racing thoughts                              |
| <input type="checkbox"/> Decreased energy     | <input type="checkbox"/> Anxiety/Worry                     | <input type="checkbox"/> Increased energy                             |
| <input type="checkbox"/> Irritable mood       | <input type="checkbox"/> Intense fear                      | <input type="checkbox"/> Sexual problem                               |
| <input type="checkbox"/> Mood swings          | <input type="checkbox"/> Short attention span              | <input type="checkbox"/> Stomach aches                                |
| <input type="checkbox"/> Socially withdrawn   | <input type="checkbox"/> Hyperactivity                     | <input type="checkbox"/> Headaches                                    |
| <input type="checkbox"/> Increase crying      | <input type="checkbox"/> Impulsive                         | <input type="checkbox"/> Conflicts with peers                         |
| <input type="checkbox"/> Suicidal thoughts    | <input type="checkbox"/> Daydreaming                       | <input type="checkbox"/> Rapid heart beat                             |
| <input type="checkbox"/> Suicidal attempt     | <input type="checkbox"/> Indecisive                        | <input type="checkbox"/> Reckless or self-abusive behavior            |
| <input type="checkbox"/> Memory problem       | <input type="checkbox"/> Perfectionist                     | <input type="checkbox"/> Conflicts with others                        |
| <input type="checkbox"/> Temper outbursts     | <input type="checkbox"/> Change of appetite                | <input type="checkbox"/> Aggressive behavior                          |
| <input type="checkbox"/> Insomnia             | <input type="checkbox"/> Poor concentration                | <input type="checkbox"/> Less interested in fun activities            |
| <input type="checkbox"/> Thoughts of death    | <input type="checkbox"/> Easily distracted                 | <input type="checkbox"/> More talkative                               |
| <input type="checkbox"/> Low self-esteem      | <input type="checkbox"/> Avoids crowds                     | <input type="checkbox"/> Believe that others are plotting against you |
| <input type="checkbox"/> Easily startled      | <input type="checkbox"/> Muscle tension                    | <input type="checkbox"/> Constantly on the watch for danger           |
| <input type="checkbox"/> Easily fatigued      | <input type="checkbox"/> Panic attacks                     | <input type="checkbox"/> Feels like things are not real               |
| <input type="checkbox"/> Sleeps too much      | <input type="checkbox"/> Easily confused                   | <input type="checkbox"/> Fears gaining weight                         |
| <input type="checkbox"/> Binge eating         | <input type="checkbox"/> Makes self vomit                  | <input type="checkbox"/> Gambling problem                             |
| <input type="checkbox"/> Stealing             | <input type="checkbox"/> Fire setting                      | <input type="checkbox"/> Hair pulling                                 |
| <input type="checkbox"/> Dramatic             | <input type="checkbox"/> Avoids conflict                   | <input type="checkbox"/> Enjoys being center of attention             |
| <input type="checkbox"/> Other problem        | <input type="checkbox"/> Exposed to life threatening event |   |

## SOCIAL HISTORY

Describe your friendships as a child: \_\_\_\_\_

How many close friends do you now have? \_\_\_\_\_ Describe your best friend: \_\_\_\_\_

What do you like to do with your friends? \_\_\_\_\_

Involvement in social organizations (i.e. church, clubs, organizations): \_\_\_\_\_

## HEALTH HISTORY (Please fill in completely, even if some things do not seem important)

Illnesses & Hospitalizations	Age	Length	Fever – Unconscious?	Treatment & Aftereffects

Accidents	Age	Unconscious?	Treatment & Aftereffects

List all <b>medications</b> you are now taking	Name of Dr. prescribing	Purpose of medication

  

List all <i>psychiatric</i> medications you have taken in the <i>past</i> .	Name of Dr. prescribing	Purpose of medication

List all your current medical problems: \_\_\_\_\_

\_\_\_\_\_

Name of your primary physician: \_\_\_\_\_

Physician's address and phone number: \_\_\_\_\_

Describe any weight loss or gain in the past year: \_\_\_\_\_

Describe your eating habits: \_\_\_\_\_

Describe how much you exercise: \_\_\_\_\_

How much do you smoke? \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Describe any sleep difficulties: \_\_\_\_\_

Head injuries? \_\_\_\_ No \_\_\_\_ Yes Explain: \_\_\_\_\_

Have you ever had a seizure? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

How much alcohol do you drink on weekly basis? \_\_\_\_\_

What other non-prescription drugs have you used? \_\_\_\_\_

Have you ever been charged with a D.W.I. or D.U.I? \_\_\_\_\_ Ages or years: \_\_\_\_\_

## **RELIGIOUS**

Describe your religious upbringing: \_\_\_\_\_

Church affiliation: \_\_\_\_\_

Describe your level of participation in religious activities: \_\_\_\_\_

Describe how you would feel about discussing spiritual or religious issues as a part of your evaluation or therapy:

\_\_\_\_\_

## **COUNSELING & THERAPY HISTORY**

Describe any previous psychological or psychiatric evaluation: \_\_\_\_\_

Describe any previous involvement with therapy or counseling: \_\_\_\_\_

**TREATMENT GOALS**

Describe the problem that troubles you the most: \_\_\_\_\_

\_\_\_\_\_

Why are you now coming in for therapy (versus before or later)? \_\_\_\_\_

What goals do you have for therapy? \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date