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ADULT HISTORY FORM

Client name _____ Date of Birth _____ Age _____ Today's Date _____

Presenting problems

Why I came for counseling:

How long have I had the problem? _____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms that are *currently* present)

- 0 = This symptom is not present at this time
- 1 = This symptom is present, bothers me a little, but not enough to be a problem.
- 2 = Symptom present, bothers me and affect my quality of life, but able to function okay
- 3 = Moderate impact on quality of life and/or day-to-day functioning
- 4 = Significant impact on quality of life and day-to-day functioning
- 5 = Serious impact on quality of life and interferes with day-to-day functioning

Symptom	Severity	Symptom	Severity	Symptom	Severity
Depressed mood	0 1 2 3 4 5	Hearing/seeing things	0 1 2 3 4 5	Thoughts of hurting myself	0 1 2 3 4 5
Worrying	0 1 2 3 4 5	Feel I'm being watched	0 1 2 3 4 5	Thoughts of killing myself	0 1 2 3 4 5
Difficulty concentrating	0 1 2 3 4 5	Feel others are against me	0 1 2 3 4 5	Heart racing	0 1 2 3 4 5
Angry feelings	0 1 2 3 4 5	Loss of interest in things	0 1 2 3 4 5	Twitches/spasms	0 1 2 3 4 5
Angry behavior	0 1 2 3 4 5	Temper outbursts	0 1 2 3 4 5	Knot in stomach	0 1 2 3 4 5
Feeling anxious/nervous	0 1 2 3 4 5	Thoughts coming too fast	0 1 2 3 4 5	Fear of places	0 1 2 3 4 5
Panic attacks	0 1 2 3 4 5	Trouble with memory	0 1 2 3 4 5	Grinding of teeth	0 1 2 3 4 5
Sweaty palms	0 1 2 3 4 5	Chest pain	0 1 2 3 4 5	Back pain	0 1 2 3 4 5
Mind going blank	0 1 2 3 4 5	Cry easily	0 1 2 3 4 5	Upset stomach	0 1 2 3 4 5
Poor appetite	0 1 2 3 4 5	Tiredness/fatigue	0 1 2 3 4 5		
Easily annoyed/irritated	0 1 2 3 4 5	Sleeping too much	0 1 2 3 4 5		
Lump in throat	0 1 2 3 4 5	Sleeping too little	0 1 2 3 4 5		
Difficulty falling asleep	0 1 2 3 4 5	Poor appetite/weight loss	0 1 2 3 4 5		
Difficulty staying asleep	0 1 2 3 4 5	Guilty feelings	0 1 2 3 4 5		

EMOTIONAL/PSYCHIATRIC HISTORY

Have you been in counseling before? ___ Yes ___ No

Name of Counselor	Counselor Address	Counselor Phone No.	Dates of service	How many sessions?

Depression								
Eating Disorder								
Post-traumatic stress								
Schizophrenia								
Suicide attempt								

FAMILY HISTORY

Describe childhood family experience (circle all that apply):

Outstanding, warm, supportive Normal, adequate, average Inconsistent or chaotic environment

Witnessed physical/emotional/sexual abuse Experienced physical/emotional/sexual abuse

Age of emancipation from home: _____ Circumstances: _____

Special circumstances during childhood: _____

MY MARITAL STATUS	Not currently in a relationship	People living in my household			
Single, never married	Never been in a serious relationship	Name	Age	Sex	Rel. to me
Engaged _____ months	Currently in a serious relationship				
Marriage #1 _____ years	Currently living with a partner				
Marriage #2 _____ years	Happy with current relationship				
Marriage #3 _____ years	Current relationship needs work				
Marriage #4 _____ years	Unhappy with current relationship				
Divorce/breakup #1 year: _____	Reason: _____				
Divorce/breakup #2 year: _____	Reason: _____				
Divorce/breakup #3 year: _____	Reason: _____				
Divorce/breakup #4 year: _____	Reason: _____				

Children who do not live with me (names/ages): _____

Describe any past or current significant issues in intimate relationships: _____

Describe any past or current significant issues in other immediate family relationships: _____

RELIGION/SPIRITUALITY

No	Yes	
		Do you feel that you have a purpose in life?
		Do you believe in a power greater than yourself?
		Do you feel that your morals, beliefs and values have been compromised due to alcohol/drug use?
		Were you raised with a religion as a child?
		If yes, what denomination?
		Do you currently practice any spiritual activities such as praying, attending church, member of choir, reading, mass, meditation, journal?
		If yes, list activities:
		Briefly describe what the word "God" means to you:

Medical history

Describe current health: [] Good [] Fair [] Poor

Name of personal physician: _____

Address: _____ Phone number: _____

Name of psychiatrist (if any) : _____

Address: _____ Phone number: _____

Date of last physical exam: _____

List any abnormal test results: _____

Describe any serious hospitalizations or accidents:

Date _____ Age _____ Reason _____

Date _____ Age _____ Reason _____

Date _____ Age _____ Reason _____

Self	Age at first use	Used in past 6 months
Alcohol – prefer <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor		
Amphetamines / Meth / Speed		
Barbiturates / Downers		
Caffeine		
Cocaine / Crack		
Hallucinogens (LSD, mushrooms, acid)		
Inhalants (paint, glue, gas)		
Marijuana		
Nicotine		
PCP		
Painkillers (morphine / heroin / Oxycotin)		
Steroids		
Prescription drugs		
Other:		

Check all circumstances that apply to you regarding your use of drugs and/or alcohol:

- Used to sleep Relieve emotional pain Relieve anxiety To avoid withdrawal To get rid of hallucinations
 Used to relax Relieve physical pain Relieve anxiety To function socially Morning Use Used alone

Consequences of substance use:

- Hangovers Assaults Overdose
 Withdrawal symptoms Job loss Sleep disturbance
 Loss of control of amount used Blackouts Relationship conflicts
 Binges Tolerance changes Legal problems
 Seizures Suicidal impulses Medical conditions Arrests

Treatment history:

- Outpatient Inpatient 12-step program Stopped on own

No Yes

- Has anybody complained about your substance use? Who? _____
 Have you ever received a DUI? If yes, how many? _____ Dates _____
 Have you had any other legal problems where alcohol or drugs were involved? If yes, explain

- Have you ever awakened the morning after using substances the night before and found that you could not remember part of the evening before?
 Have you ever gone for more than three days without using substances without a struggle?
 Did you ever need a drink first thing in the morning to get started?
 Have you had any of the following problems when you stopped or cut down on your substance use? (check all that apply)
 Shakes Seeing or hearing things that aren't there Heavy sweating, heart beating fast
 Unable to sleep Feeling anxious or depressed DT's or seizures
 Have you ever used substances to keep from having withdrawal symptoms or to make them go away?
 Did you continue to use substances, knowing it caused you to have health problems or injuries?
 Have you ever continued to use substances while taking medication that was dangerous to take with that substance?
 Have substances ever caused you to feel: disinterested in things depressed paranoid
 Did these problems cause you to cut down on substance use?
 Have you ever spent a lot of time getting, using, or getting over the effects?
 Have there been many days when you used much larger amounts of substances than you intended to when you began?
 Have you tried to cut down on your substance use but found that you couldn't?
 Did you ever feel sick because you stopped or cut down on substance use?
 Have you ever felt you needed larger amounts of substances to get the same effect as before?
 Have substances caused problems with your family, friends, workers, or with the police?
 Have you given up, or greatly reduced, important activities such as sports, work, or associating with friends or relatives in order to use substances?

Self-Evaluation:

Personal Strengths

Personal Weaknesses
