ADULT CLIENT HISTORY

Print

IDENTIFYING INFORMATION

CLIENT NAME: _____ AGE: _____ RACE: _____ SEX: Male

OTHERS IN HOUSE: ☐ Parents ☐ Friend ☐ Children ☐ Siblings ☐ Others

Referred By: _____

PERSON COMPLETING THIS FORM (if not the client):

Name: _____ Relationship to client: _____

CURRENT CONCERNS:
Why is the client seeking treatment? _____

_____

Check any of the following behaviors that have recently applied to the client:

☐ Feeling sad/down	☐ Too much energy	☐ Decreased interest in activities
☐ Being overly irritable	☐ Feeling anxious	☐ Feeling on top of the world
☐ Change in sleeping patterns	☐ Panic attack(s)	☐ Engaging in risky behavior
☐ Feeling worried a lot	☐ Excessive fears	☐ Feeling excessively tired
☐ Feeling worthless or guilty	☐ Withdrawal, isolation	☐ Feeling uncomfortable around others
☐ Difficulty making decisions	☐ Thoughts of death	☐ Suicide attempt
☐ Feeling overwhelmed	☐ Using drugs	☐ Change in eating patterns
☐ Obsessions (thoughts you can't get rid of)	☐ Agitation/being upset	☐ Being overactive
☐ Losing things	☐ Losing track of time	☐ Being disorganized
☐ Relationship difficulties	☐ Feeling disconnected from oneself	☐ Decreased enjoyment
☐ Significant weight changes	☐ Feeling restless, or slowed down	☐ Feeling judged by others
☐ Decreased ability to concentrate	☐ Thoughts of hurting self or others	☐ Unpleasant thoughts about an event
☐ Being impulsive	☐ Temper outbursts/aggression	☐ Using alcohol (___day week month)
☐ Having feelings of unreality	☐ Compulsions (doing things over & over)	☐ Using tobacco products

HISTORY OF TREATMENT

Has the client/family ever received counseling for emotional or substance abuse problems? ☐ Yes ☐ No

Explain if yes: _____

Problem treated for: _____

Provider: _____ When treated? _____

Problem treated for: _____

Provider: _____ When treated? _____

FAMILY HISTORY

Spouse (or significant other's) name: _____ Age: ____ Health: _____ Occupation: _____

Home phone # _____ Cell #:_____ Work #:_____

Children/Stepchildren name and ages: _____

Any significant details regarding Children/Stepchildren? _____

Any significant details about family members (other than Children/Stepchildren)? _____

_____

Any family history of mental health treatment? _____

Any significant individuals (other than family) in the home or client's background? _____

Significant life events (include births, deaths, moves, traumatic events): _____

MARITAL HISTORY

Previously married? No If yes, please give name of ex-spouse and date(s) of previous marriage: _____

_____

History of marital problems: _____

MEDICAL HISTORY

Are there concerns regarding medical treatment that the client is currently receiving or has recently received? ☐ Yes ☐ No

Explain if yes: _____

Please list all medications: _____

Name of prescribing doctor:_____

Please list any significant medical problems for other members of the family: _____

Has the client ever been physically or sexually abused? ☐ Yes ☐ No Explain if yes: _____

_____

EDUCATION

Current school or last school attended: _____

Grade level: _____ Academic Functioning (grades): _____

Did the client ever receive special services in school? _____

Academic problems or special needs: _____

VOCATIONAL

Present job: _____ Employer: _____

Length of time at present job: _____ Work history: _____

_____

LEGAL HISTORY

Are there any legal charges pending? ☐ Yes ☐ No

Has the client ever been arrested? ☐ Yes ☐ No

Specify: _____

_____

_____

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____