Counseling with C.A.R.E.

COMPASSION • ACCEPTANCE • RESPECT • EMPATHY

ADULT INFORMATION & HISTORY

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Today's Date: _____

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Local Address: _____
(Number and Street) (City) (State) (Zip)

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____

Home Phone: (_____)_____ May we leave a message? □Yes □No

Cell/Other Phone: (_____)_____ May we leave a message? □Yes □No

E-mail*: _____ May we e-mail you? □Yes □No

***Please be aware that e-mails are not confidential.**

Insurance Company: _____ Policy #: _____

Subscriber/Relationship: _____ DOB: _____

Referred by: _____

Emergency Contact: _____ Contact #: _____
Name/Relationship

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □Yes □No

Have you had previous psychotherapy? □No □Yes
If Yes, please provide previous therapist's name_____

Are you currently taking prescribed psychiatric medication (anti-depressants or others)? □Yes □No
If Yes, please list: _____
If No, have you been previously prescribed psychiatric medication? □Yes □No
If Yes, please list and provide dates taken: _____
_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____
_____
_____

3. Are you having any problems with your sleep habits? ☐ No ☐ Yes
If yes, check where applicable:
☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep
☐ Disturbing dreams ☐ Other _____

4. How many times per week do you exercise? _____ How long each time? _____

5. Are you having any difficulty with appetite or eating habits? ☐ No ☐ Yes
If Yes, check where applicable:
☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting
Have you experienced a significant weight change in the last 2 months? ☐ No ☐ Yes

6. Do you regularly use alcohol? ☐ No ☐ Yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period?____

7. How often do you engage recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

8. Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Have you had them in the past? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

9. Are you currently in a romantic relationship? ☐ No ☐ Yes
If yes, how long have you been in this relationship? _____
On a scale of 1-10, how would you rate the quality of your current relationship? ____

10. In the last year, have you experienced any significant life changes or stressors: _____
_____
_____

Have you ever experienced:

Extreme depressed mood	Yes	No	Alcohol/Substance Abuse	Yes	No
Wild Mood Swings	Yes	No	Frequent Body Complaints	Yes	No
Rapid Speech	Yes	No	Eating Disorder	Yes	No
Extreme Anxiety	Yes	No	Body Image Problems	Yes	No
Panic Attacks	Yes	No	Repetitive Thoughts	Yes	No
Phobias	Yes	No	(e.g., Obsessions)		
Sleep Disturbances	Yes	No	Repetitive Behaviors	Yes	No
Hallucinations	Yes	No	(e.g., Frequent Checking, Hand-Washing)		
Unexplained losses of time	Yes	No	Homicidal Thoughts	Yes	No
Unexplained memory lapses	Yes	No	Suicide Attempt	Yes	No

OCCUPATIONAL INFORMATION:

Are you currently employed? ☐ No ☐ Yes
If Yes, who is your current employer/position? _____
If Yes, are you happy at your current position? _____
Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ☐ No ☐ Yes
If Yes, what is your faith? _____
If No, do you consider yourself to be spiritual? ☐ No ☐ Yes

What would you consider to be your source of strength? _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any or all that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty			**Family Member (s)**
Depression	Yes	No	
Bipolar Disorder	Yes	No	
Anxiety Disorders	Yes	No	
Panic Attacks	Yes	No	
Schizophrenia	Yes	No	
Alcohol/Substance Abuse	Yes	No	
Eating Disorders	Yes	No	
Learning Disabilities	Yes	No	
Trauma History	Yes	No	
Suicide Attempts	Yes	No	

OTHER INFORMATION:
What are your strengths? _____

What do you like most about yourself? _____

What are effective coping strategies that you've learned? _____

What are your goals for therapy? _____