LIFE STRATEGIES
Counseling Center LLC
"Building Bridges For Successful Living"

ADULT HISTORY FORM

Please understand that this form is used with a wide variety of people and situations. All questions may not seem to apply to you, but all are important. Answer as much as possible to the best of your ability. Please address any questions you may have with your counselor. Thank you for entrusting us with such valuable information; we will always treat is as such.

Client's Name: _____ **Today's Date:** _____

Preferred Name: _____ **Gender:** ☐Male ☐Female

Date of Birth: _____ **Age:** _____

Address: _____**City** _____ **State**_____**Zip**_____

Phone Number_____ **Can messages be left at this number Yes**____ **No**_____

Can text messages be sent at this number Yes_____ **No**_____

Email Address:_____ **Can emails be sent: Yes**_____ **No**_____

Marital Status: ☐Married ☐Divorced ☐Single ☐Widow(er) ☐ Separated

Are you currently, or have you ever served, in the Military? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No **If yes, of which war?** _____

Present Church Affiliation:_____

Who referred you to us? _____

Please share the reason you are seeking services? _____

_____

_____

How long has this been a concern? _____

EDUCATIONAL HISTORY:

High School Graduate? ☐ Yes ☐ No ☐ GED

Highest Degree: _____

Current Student: ☐ Yes ☐ No **If yes, what is your status?** ☐ Part-time ☐ Full-time

Type of Student: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Did you attend a public or private school? ☐Public ☐Private ☐Other _____

If yes, how long did you attend school? _____

How would you rate your overall experience? ☐ Excellent ☐ Good☐ Fair ☐ Poor

Any specific school diagnosis (i.e., LD, ADHD, etc.): _____

Please Explain: _____

_____

OCCUPATIONAL HISTORY:

Employed: ☐ Yes ☐ No ☐ Retired ☐ Disabled

Name of Current Employer: _____

Please check one: ☐ Part-time ☐ Full-time ☐ Other

If other, please specify: _____

Length of time with current job: _____

Please list jobs and length of employment for each:

Job Name	Position	How Long	Reason for Leaving
1.			
2.			
3.			
4.			

FAMILY INFORMATION:

Please list all individuals living in your household (please exclude yourself):

Name **Relationship** **Age** **Name** **Relationship** **Age**

_____ _____

_____ _____

_____ _____

What is your parent's current marital status? _____

Blended Famly? ☐ Yes ☐ No **Please Explain:** _____

_____

Who raised you? _____ **Relationship**: _____

Your ages(s) when with him/her/them: _____

Were you raised in a religious environment? ☐ Yes ☐ No

If yes, which religion? _____

Were you adopted? ☐ Yes ☐ No **If yes, how old were you when adopted?** _____

How has adoption impacted your life? _____

_____

Do you have children who do not live with you? ☐ Yes ☐ No

If yes, what are their ages? _____ **Are they married?** ☐ Yes ☐ No

Do they have children? ☐ Yes ☐ No

Please note any other information about your current family or family of origin: _____

_____

Have you ever experienced the death of an individual significant to you? ☐Yes ☐No

If yes, please explain: _____

_____

SUPPORT SYSTEM:

Which reflects your current # of close friends/family members: ☐None ☐Some ☐A lot

Name of Significant Other / Relationship: _____

Family/Friends/Co-workers (please list):

Name/Relationship	Name/Relationship

Do you participate in social clubs? ☐Yes ☐No

Are you a member of a church/religious group? ☐Yes ☐No

Please list any other activities or community agencies in which you are involved: _____

_____

HEALTH HABITS:

Do you exercise? ☐ Yes ☐ No

If yes, please describe (exercise/length/frequency): _____

_____

SLEEP HABITS: (Please mark all that presently apply)

☐ Cannot sleep at all
☐ Difficulty getting to sleep
☐ Do not feel rested after sleep
☐ Dreams: Good/Bad
☐ Nightmares
☐ Sleep all the time
☐ Sleep more than usual
☐ Sleep through the night
☐ Wake-up during the night
☐ Wake up too early

Number of hours you sleep per day: _____

EATING HABITS: (Please mark all that apply)

Current appetite:	☐ Good	☐ Fair	☐ Poor
Past appetite:	☐ Good	☐ Fair	☐ Poor
Do you skip meals?	☐ Yes	☐ No	
Do you eat a lot?	☐ Yes	☐ No	
Do you vomit?	☐ Yes	☐ No	
Weight changes/fluctuations?	☐ Yes	☐ No	

If yes, please explain: _____

_____

LEGAL HISTORY:

Please mark any of the following that applies:

As an Adult:	**As a Juvenile:**
☐ Police involvement	☐ Police involvement
☐ Arrests	☐ Arrests
☐ Convictions	☐ Convictions
☐ Probation/parole	☐ Probation/parole

Please explain: _____

_____

COUNSELING HISTORY:

Have you ever received counseling, therapy or psychiatric treatment before? ☐Yes ☐No

If yes, please check the all that apply:

☐ Outpatient ☐ Day Treatment ☐ Residential ☐Hospitalization

Please Explain: _____

_____

If you received treatment before, was it helpful? _____

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

If yes, when _____ **Please explain:** _____

_____

PERSONAL MEDICAL HISTORY:

What is your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please mark any symptoms you are presently experiencing or have experienced in the past:

Now|Past	**Now|Past**	**Now|Past**
☐ ☐ Anxiety	☐ ☐ Inattention	☐ ☐ Poor self-image
☐ ☐ Body image problems	☐ ☐ Increased anger	☐ ☐ Problems with intimacy
☐ ☐ Changes in eating	☐ ☐ Increased fear	☐ ☐ Problems sleeping
☐ ☐ Cutting on self	☐ ☐ Increased feelings of guilt	☐ ☐ Racing Heart
☐ ☐ Daydreaming	☐ ☐ Increased sex drive	☐ ☐ Racing Thoughts
☐ ☐ Decreased sex drive	☐ ☐ Intrusive memories	☐ ☐ Self-blame
☐ ☐ Distractibility	☐ ☐ Mood changes	☐ ☐ Startle responses
☐ ☐ Excessive Crying	☐ ☐ Nervousness	☐ ☐ Stomach Problems
☐ ☐ Feelings of loss of control	☐ ☐ Nightmares	☐ ☐ Trust issues
☐ ☐ Flashbacks	☐ ☐ Panic attacks	☐ ☐ Vomiting

Please Explain: _____

_____

Please mark any conditions you are presently experiencing or have experienced in the past:

Now	Past		Now	Past		Now	Past	
☐	☐	Allergies to medications	☐	☐	Eyes/ears/nose/throat	☐	☐	Migraine headaches
☐	☐	Allergies: Other	☐	☐	Gastro-Intestine	☐	☐	Muscles/joints/bones
☐	☐	Blood disease	☐	☐	Gynecological	☐	☐	Nervous system
☐	☐	Broken Bones	☐	☐	Heart disease	☐	☐	Prostate
☐	☐	Cancer	☐	☐	Hepatitis	☐	☐	Physical Disability
☐	☐	Developmental issues	☐	☐	High blood pressure	☐	☐	Seizures
☐	☐	Diabetes	☐	☐	HIV	☐	☐	Serious childhood illness
☐	☐	Difficulties during your birth	☐	☐	Hypoglycemia	☐	☐	Thyroid
☐	☐	Difficulties giving birth	☐	☐	Kidney/bladder/genital	☐	☐	Under/Over Weight
☐	☐	Digestive system	☐	☐	Liver disease			
☐	☐	Epilepsy	☐	☐	Lung disease			

Please Explain: _____

_____

Has anyone in your family experienced any of the above symptoms or conditions?

Condition	Family Member

Have you ever experienced any significant injuries? ☐Yes ☐No

Please Explain: _____

_____

Please list any surgeries: _____

_____

List any significant childhood illnesses: _____

_____

Have you ever been pregnant? ☐Yes ☐No **Have you had any miscarriages?** ☐Yes ☐No

How many pregnancies? _____ **How many full-term births?** _____

Have you ever been hit, pushed, restrained, confined, physically coerced, injured, threatened or stalked by a partner/spouse or other? ☐Yes ☐No

If yes, please explain: _____

_____

Please list all the medications you are currently taking:

Medication	Dosage	Reason Prescribed

Describe how you currently deal with stress: _____

_____

Describe how you have dealt with stress in the past: _____

_____

SUBSTANCE USE HISTORY:

Have you ever used any of the following substances? (Please check all that apply)

Type	Amount	How Often	Age Started	Date Last Used
Coffee: ☐Yes ☐No				
Alcohol: ☐Yes ☐No				
Tea: ☐Yes ☐No				
Soda: ☐Yes ☐No				
Tobacco Products: ☐Yes ☐No				
Energy drinks: ☐Yes ☐No				

Have you ever used substances such as cocaine, marijuana, heroin, crack, ecstasy, non-prescribed medicine? ☐ Yes ☐No If yes, please explain below:

Type	Amount	How Often	Age Started	Date Last Used

Describe any problem(s) you have experienced as a result of your use: _____

_____

Please mark any of the following support groups you attend, and indicate # of meetings:

1. AA: ☐Yes ☐No ☐N/A # of meetings per week: _____
2. NA: ☐Yes ☐No ☐N/A # of meetings per week: _____
3. OA: ☐Yes ☐No ☐N/A # of meetings per week: _____
4. Other: _____ # of meetings per week: _____

Do your friends/relatives think you drink too much alcohol, overuse prescription drugs, coffee/tea, or soda? ☐ Yes ☐ No

If yes, please explain: _____

_____

Please provide any other information that would be helpful for your therapist to know:

_____

_____

_____

_____

What would you like to accomplish during therapy? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I understand that his information is being provided to my mental health therapist only. It is my responsibility to share relevant medical information with my Primary Care Physician.

Completed by: _____Date:_____

Reviewed by: _____Date: _____