LPCC, NCC, CCMHC
STEVEN M. SCHOSER
Helping People Heal

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Adult Information Form

Name:_____ Date:_____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today:_____

_____

Please check all to the behaviors and symptoms that you consider problematic:

- ☐Distractibility
- ☐Hyperactivity
- ☐Impulsivity
- ☐Boredom
- ☐Poor memory/confusion
- ☐Seasonal mood changes
- ☐Sadness/depression
- ☐Loss of pleasure/interest
- ☐Hopelessness
- ☐Thoughts of death
- ☐Self-harm behaviors
- ☐Crying spells
- ☐Loneliness
- ☐Low self-worth
- ☐Guilt/shame
- ☐Fatigue
- ☐Change in appetite
- ☐Lack of motivation
- ☐Withdrawal form people
- ☐Anxiety/worry
- ☐Panic attacks
- ☐Fear away from home
- ☐Social discomfort
- ☐Obsessive thoughts
- ☐Compulsive behavior
- ☐Aggression/fights
- ☐Frequent arguments
- ☐Irritability/anger
- ☐Homicidal thoughts
- ☐Flashbacks
- ☐Hearing voices
- ☐Visual hallucinations
- ☐Suspicion/paranoia
- ☐Racing thoughts
- ☐Excessive energy
- ☐Wide mood swings
- ☐Sleep problems
- ☐Nightmares
- ☐Eating problems
- ☐Gambling problems
- ☐Computer addiction
- ☐Problems with pornography
- ☐Parenting problems
- ☐Sexual problems
- ☐Relationship problems
- ☐Work/school problems
- ☐Alcohol/drug use
- ☐Other:_____

Are your problems affecting any of the following?

- ☐Handling everyday tasks
- ☐Work/school
- ☐Recreational activities
- ☐Self esteem
- ☐Housing
- ☐Sexual activities
- ☐Relationships
- ☐Legal matters
- ☐Health
- ☐Hygiene
- ☐Finances

☐Yes ☐No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe:_____

_____

☐Yes ☐No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:_____

_____

☐Yes ☐No Have you recently been physically hurt or threatened by someone else? If yes, please describe:_____

_____

Therapist Notes:

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Name:_____ _____

Family and Developmental History

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

☐Parents legally married or living together
☐Parents temporarily separated
☐Parents divorced or permanently separated

☐Mother remarried: Number of times:_____
☐Father remarried: Number of times:_____

Please check if you have experienced any of the following types of trauma or loss:

☐Emotional abuse
☐Sexual abuse
☐Physical abuse
☐Parent substance abuse
☐Teen pregnancy
☐Neglect
☐Violence in the home
☐Crime victim
☐Parent illness
☐Placed a child for adoption
☐Lived in a foster home
☐Multiple family moves
☐Homelessness
☐Loss of a loved one
☐Financial problems

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Previous Mental Health Treatment

Yes	No	Type of Treatment	When	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (Mental Health)			
		Psychiatric Hospitalization			
		Drug/ Alcohol Treatment			
		Self-Help/Support Groups			

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Name:_____

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/Crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

☐Yes ☐No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe:_____

☐Yes ☐No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, describe:

Therapist Notes:

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MEDICAL INFORMATION

Date of last physical exam:_____

Have you experienced any of the following medical conditions during your lifetime?

☐Allergies ☐Asthma ☐Headaches ☐Stomach aches
☐Chronic pain ☐Surgery ☐Serious accident ☐Head Injury
☐Dizziness/fainting ☐Meningitis ☐Seizures ☐Vision problems
☐High fevers ☐Diabetes ☐Hearing problems ☐Miscarriage
☐Sexually transmitted disease ☐Abortion ☐Sleep disorder ☐Other:_____

Please list any CURRENT health concerns:_____

Current prescription medications: ☐NONE

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.):_____

Allergies and/or adverse reactions to medications: ☐NONE
If yes, please list:_____

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Name:_____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply)
☐Family ☐Neighbors ☐Friends ☐Students ☐Co-Workers ☐Support/Self-Help Group
☐Community Group ☐Religious/Spiritual Center (Which one?_____)

To which cultural, subcultural group(s) are you a part of?_____
What do you consider your primary ethnicity:_____
Do you have a secondary ethnicity? If yes, what?_____
If you are experiencing any difficulties due to cultural or ethnic issues, please describe:_____
_____

How important are spiritual matters to you? ☐Not at all ☐Little ☐Somewhat ☐Very much?
☐Yes ☐No Would you like spiritual/religious beliefs to be incorporated into your counseling?
Please describe your strengths, skills and talents?_____
_____
Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____
_____

Therapist Notes:

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MISCELLANEOUS INFROMATION

Employment

Employer:_____ Position:_____
Lengths of time at current employer:_____ Job Duties:_____
Stress level of positions: ☐ Low ☐ Medium ☐ High
Other jobs you have held:_____

Education

☐ Yes ☐No Are you currently attend school?

☐ High School Graduate Or ☐GED Year:_____
☐ Associate's Degree Year:_____ Major area of study:_____
☐ Undergraduate Degree Year:_____ Major area of study:_____
☐ Graduate Degree Year:_____ Major area of study:_____

Military Service

☐Yes ☐No Have you been/are you currently in the military? (if no, skip remainder of this section)
Branch:_____Date of Discharge:_____Type of Discharge:_____Rank:_____ Combat ☐Yes ☐No

Legal

☐Yes ☐No Have you ever been convicted of a misdemeanor or felony? If yes, please explain:_____
☐Yes ☐No Are you currently involved in any divorce or child custody proceedings? If yes, please explain:_____

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ADDITIONAL THERAPIST NOTES

Init: