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ADULT CLIENT HISTORY

Name _____ Today's Date: _____

Birthdate _____ Current Age_____

Gender: _____Male _____Female _____Other (please indicate)_____

Occupation _____

Employer _____ Typical Work Hours _____

Ethnicity: _____ Primary Language: _____

Other languages you speak: _____

FAMILY

Marital Status (circle): Married Domestic Partner Separated Divorced Widowed Never Married

Spouse/Partner Name_____Age_____Relationship Length_____

Spouse/Partner's Occupation_____ Employer_____

Were you married previously? _____ If yes, how many times: _____

Your Children Living with You: (Please indicate if adopted or step-children)

Name_____Age_____ Gender_____

Student/Occupational Status_____School/Employer_____

Name_____Age_____ Gender_____

Student/Occupational Status_____School/Employer_____

Name_____Age_____ Gender_____

Student/Occupational Status_____School/Employer_____

Your Children Living Separately from You: (Please indicate if adopted or step-children)

Name_____Age_____ Gender_____

Student/Occupational Status_____School/Employer_____

Name_____Age_____ Gender_____

Student/Occupational Status_____School/Employer_____

Name_____Age_____ Gender_____

Student/Occupational Status_____School/Employer_____

Others Residing in Home:

Name	Relationship to You	Age	Gender	Student/Occupational Status

Pets: Please list any pets living with you: _____
_____.

Family of Origin:

Parent 1: Name_____ Current age: _____Where living_____

If deceased, age at death_____ Cause of death_____

Parent 2: Name_____ Current age: _____Where living_____

If deceased, age at death_____ Cause of death_____

Siblings:

Name	Age	Gender	Student/Occupational Status	Location

EDUCATION

1. Highest level of formal education achieved_____

2. Schools Attended:

Name of High School:_____ Year Graduated_____

Name:_____ Degree_____ Year Awarded_____ Major_____

Name:_____ Degree_____ Year Awarded_____ Major_____

3. Did you receive any special educational/remedial services/accommodations in school? Please explain:

_____
_____.

4. Other Training, Apprenticeships, etc.:

Where Attended: _____ Type of Training_____ Years Attended_____
Where Attended: _____ Type of Training_____ Years Attended_____

MEDICAL/DEVELOPMENTAL HISTORY

1. Name(s) of your Physicians:

Primary Care Physician _____ Location_____

Physician Name_____Specialty_____Location_____

Physician Name_____Specialty_____Location_____

2. Please list medications currently taken by client, including dosage:

Medication_____ Dosage_____ For What Condition_____

Medication_____ Dosage_____ For What Condition_____

Medication_____ Dosage_____ For What Condition_____

Medication_____ Dosage_____ For What Condition_____

3. Please list any significant illnesses, injuries, or hospitalization/surgeries experienced by the client:

Illness/Injury Approximate Date Hospitalized? Enduring Effects

_____

_____

_____

4. Do you now or have you ever experienced any of the following (describe condition & approximate dates):

a. Sleep problems_____

b. Eating problems_____

c. Unusual weight gain/loss_____

d. Vision/hearing problems_____

e. Cardiac/Heart Problems_____

f. Allergies/Asthma_____

g. Convulsions or seizures_____

h. Nervous tics_____

i. Chronic stomachaches_____

j. Chronic headaches_____

k. Concussions_____

l. Diabetes_____

5. How often do you:

Smoke cigarettes/cigars/pipe_____ Drink alcohol_____

Use recreational drugs (list types) _____

6. Please list any significant medical or psychological history in your parents or siblings:

_____

_____.

7. Please list any other current medical or psychological issues in the immediate or extended family that are contributing significant stress to the client:

_____

_____.

8. Please list your previous psychotherapy, counseling, or psychiatric treatment or psychological evaluations:

Name/Treatment	Location	Approximate Date
_____		
_____		
_____		

9. To your knowledge, was there anything unusual about your mother's pregnancy with you or your birth?

_____

_____.

10. To your knowledge, circle the description of your accomplishment of these developmental milestones:

	Normal	Early	Late	Significant Delay	Don't Know
a Beginning to walk:	_____	_____	_____	_____	_____
b. Beginning to talk:	_____	_____	_____	_____	_____
c. Speak in sentences:	_____	_____	_____	_____	_____
d. Bladder control:	_____	_____	_____	_____	_____
e. Bowel control:	_____	_____	_____	_____	_____
f. Ride a bike:	_____	_____	_____	_____	_____
g. Begin to read:	_____	_____	_____	_____	_____
h. Begin to write:	_____	_____	_____	_____	_____

OTHER SOCIAL BACKGROUND

1. How would you describe your friendships and social life?
   _____I'm a loner.
   _____I have one close friend.
   _____I have several close friends.
   _____I have one/several close friends and a wider group of casual friends.
   _____I don't have any close friends but have lots of casual friends and acquaintances.

2. Check all of the descriptions below that apply to you:
   _____I make friends easily.
   _____I have long-term friendships that I've maintained over many years.
   _____I have an active social life.
   _____I tend to socialize only with family members.
   _____I initiate social activities with others (friends, family) frequently.
   _____It's hard for me to make friends.
   _____I think of myself as a leader.
   _____I am more a follower than a leader.
   _____I'm not really a leader or a follower but more of an active contributor and supporter in my social realm.

3. Religious Affiliation_____

Church Participation (circle one): active causal occasional not attending

4. List any hobbies, sports, clubs/organizations, or other special interests: _____
_____.

5. Who do you consider to be your heroes, or people that serve as a role model for you? _____
_____
_____
_____.

What other information do you think that I should know to help me work with you?
_____
_____
_____
_____
_____.

What are the goals that you'd like us to address in our work together?
_____
_____
_____
_____
_____.

_____ _____

Signature of person completing this form Date

_____

Relationship of person completing for the client if not the client

Thank you for taking the time to complete this form. It will help in understanding and facilitating the changes that are the goal of these services.