Assigned therapist: _____

JF&CS ADULT INFORMATION FORM

NAME:_____ **NICKNAME:**_____

Date of Birth: _____/_____/_____ Gender: □ Female □ Male □ Transgender □ Decline to Answer

Address: _____

Race: □ Caucasian □ African American □ Hispanic □ Asian American □ Other: _____

Marital Status: □ Married □ Partnered □ Never Married □ Widowed □ Divorced/Separated (___/___/___)

Religion/Church Affiliation: □ Jewish □ Catholic □ Protestant □ None □ Other: _____

Primary Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Highest Education Level: _____

Military Service Branch: _____ Dates of Service: _____ Highest Rank: _____

Occupation/Employment: _____

PARTNER/SPOUSE:

Partner/Spouse's Name: _____

Preferred Phone Number: _____ □ Home □ Work □ Mobile □ Other _____

Address: (□ Same as above) _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Preferred Number: _____

CHILDREN:

Name	DOB	Gender	Grade Level and/or Occupation
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____
_____	___/___/___	_____	_____

OTHERS IN THE HOME:

Name	DOB	Gender	Grade Level and/or Occupation	Relation
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____

TOTAL NUMBER IN HOUSEHOLD: _____

What Are Your Current Concerns?: _____

_____

_____

Why Have You Sought Treatment Now?:_____

_____

What Are Your Expectations For Treatment?:_____

_____

MENTAL HEALTH HISTORY

	Self		**Family Member**	**This person's relation to you?**
Depression	☐ No	☐ Yes	☐ No	☐ Yes, _____
Anxiety	☐ No	☐ Yes	☐ No	☐ Yes, _____
Suicidal Thoughts/Actions	☐ No	☐ Yes	☐ No	☐ Yes, _____
Bipolar Disorder	☐ No	☐ Yes	☐ No	☐ Yes, _____
Alzheimer's	☐ No	☐ Yes	☐ No	☐ Yes, _____
Paranoia	☐ No	☐ Yes	☐ No	☐ Yes, _____
Learning Difficulties	☐ No	☐ Yes	☐ No	☐ Yes, _____
Attention Difficulties	☐ No	☐ Yes	☐ No	☐ Yes, _____
Hallucinations/Delusions	☐ No	☐ Yes	☐ No	☐ Yes, _____
Eating Problems	☐ No	☐ Yes	☐ No	☐ Yes, _____
Behavior Problems	☐ No	☐ Yes	☐ No	☐ Yes, _____
Sleep Problems	☐ No	☐ Yes	☐ No	☐ Yes, _____
Alcohol Addiction	☐ No	☐ Yes	☐ No	☐ Yes, _____
Drug Addiction	☐ No	☐ Yes	☐ No	☐ Yes, _____
Other Addictions	☐ No	☐ Yes	☐ No	☐ Yes, _____
Physical Abuse	☐ No	☐ Yes	☐ No	☐ Yes, _____
Sexual Abuse	☐ No	☐ Yes	☐ No	☐ Yes, _____

Any other mental health concerns you would like to mention? _____

_____

CURRENT ENVIRONMENTAL STRESSORS

Recent or Significant Death	☐ Yes ☐ No	Relation(s) to Self/Date: _____
Significant Moves	☐ Yes ☐ No	Dates/Locations: _____
Child Medical Problems	☐ Yes ☐ No	Explain: _____
Family Medical Problems	☐ Yes ☐ No	Explain: _____
Financial Problems	☐ Yes ☐ No	Explain: _____
Safety of Yourself and Others	☐ Yes ☐ No	Explain: _____
Other Stressors:		Explain: _____

STRENGTHS/AREAS OF INTEREST:

		Please explain.
Intellect	□ No	□ Yes,_____
Career/Work	□ No	□ Yes,_____
Athletic ability	□ No	□ Yes,_____
Arts and crafts/Creativity	□ No	□ Yes,_____
Musical ability	□ No	□ Yes,_____
Supportive family	□ No	□ Yes,_____
Supportive friends	□ No	□ Yes,_____
Group involvement	□ No	□ Yes,_____
Religious involvement	□ No	□ Yes,_____
Sense of humor	□ No	□ Yes,_____
Other strengths	□ No	□ Yes,_____

MENTAL HEALTH TREATMENT HISTORY:

□ No Previous Treatment or Formal Evaluation

	Dates:
□ Hospitalization(s) (number)	Most current/most recent:_____
□ Outpatient Treatment	Most current/most recent:_____
□ Formal Evaluation	Most current/most recent:_____

Have you previously met with other counselors/therapists? □ No □ Yes

Please list providers, reasons for treatment, dates of service:

_____

_____

_____

Have you previously met with a psychiatrist? □ No □ Yes

Please list psychiatrists, previous diagnoses, and dates of treatment:

_____

_____

_____

Are other providers/agencies providing services to you (mental health, vocational/education, legal, groups, etc.)?

_____

_____

_____

_____

PHYSICAL HEALTH & MEDICAL HISTORY

Please list previous medical doctors, diagnoses, and dates of treatment:

_____

_____

_____

_____

Physical Health Status: □ Excellent □ Good □ Fair □ Poor

Have you had a physical exam in the last year? □ No □ Yes (date)_____

Physician Name: _____

Current medications: □ N/A □ Yes,_____Dose_____

_____Dose_____

_____Dose_____

_____Dose_____

_____Dose_____

Current supplements: □ N/A □ Yes,_____Dose_____

(e.g., vitamins, herbals, over the counter) _____Dose_____

_____Dose_____

Please explain with dates.

Head injuries □ N/A □ Yes,_____

Concussions □ N/A □ Yes,_____

Seizures □ N/A □ Yes,_____

Serious accidents □ N/A □ Yes,_____

Major surgeries □ N/A □ Yes,_____

Medical Hospitalizations □ N/A □ Yes,_____

Medical Problems (Check all that apply)

□ AIDS/HIV+	□ Blood Pressure	□ Gout	□ Irritable Bowel	□ Osteoporosis
□ Allergies	□ Cirrhosis	□ Heart Attack	□ Kidney Disease	□ Peptic Ulcer
□ Alzheimer's	□ Cancer	□ Hepatitis	□ Lyme Disease	□ Pleurisy
□ Arthritis	□ Crohn's/Colitis	□ Heart Disease	□ Lupus	□ Parkinson's
□ Angina	□ Dermatitis	□ Herpes	□ Meningitis	□ Sinusitis
□ Asthma	□ Diabetes	□ Headaches	□ Migraine	□ Stroke
□ Atrial Fibrillation	□ Emphysema	□ Hyperthyroid	□ Multiple Sclerosis	□ Tuberculosis
□ Bronchitis	□ Epilepsy	□ Hypothyroid	□ Obesity	□ Urinary Tract

□ Other Medical Problems (specify):_____

Family Medical Health History

	Family Member		Family Member
Thyroid Disorder:	□ Yes □ No _____	Diabetes:	□ Yes □ No _____
Cancer:	□ Yes □ No _____	Heart Disease:	□ Yes □ No _____
High Blood Pressure:	□ Yes □ No _____	Weight/Eating:	□ Yes □ No _____
Bed-wetting:	□ Yes □ No _____	Seizures:	□ Yes □ No _____

Other (please include family member): _____

_____

SUBSTANCE ABUSE/DEPENDENCE

	Current	**Substance**	**Past**	**Substance**
Depressants (e.g., alcohol)	□ No	□ Yes,_____	□ No	□ Yes,_____
Stimulants (e.g., cocaine)	□ No	□ Yes,_____	□ No	□ Yes,_____
Narcotics (e.g., Demerol)	□ No	□ Yes,_____	□ No	□ Yes,_____
Hallucinogens (e.g., PCP)	□ No	□ Yes,_____	□ No	□ Yes,_____
Cannabinoids (e.g., marijuana)	□ No	□ Yes,_____	□ No	□ Yes,_____
Other Substances	□ No	□ Yes,_____	□ No	□ Yes,_____

LEGAL HISTORY

Present Charges: □ Yes □ No

Please list charge & date:

_____

_____

_____

_____

Past Charges: □ Yes □ No

Please list charge & date:

_____

_____

_____

_____

Any other current legal concerns? _____

_____

_____

Is there any other information you would like to share?

_____

_____

_____

_____

Form completed by: _____