Adult Information Form

Name_____ Date of first appointment_____
Date of Birth_____ Age____ Sex_____

Marital Status: Single__ Married___(___years) Separated___ Divorced___Widowed___

Have you ever been hospitalized? Yes___ No___

Hospital	Month/Year	Reason
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? Yes___ No___
If yes, please list:

Type of Drugs	How much?	How often?
_____	_____	_____
_____	_____	_____

Do you drink alcohol? Yes___ No ___
If yes, please list:

Type of Alcohol	How much?	How often?
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? Yes___ (___cigarettes per day) No___

Do you have any close relatives (father, mother, brother, sister) who have experienced depression or other emotional problems? Please list:_____
_____
_____

Describe any other health problems or important medical history about yourself or close family members, including chronic ailments:_____
_____
_____

Education: Please list any schools or programs you have attended:

Name	Years	Year Graduated
High School_____	_____	_____
College _____	_____	_____
Other_____	_____	_____

Employment Information:

Employer	Days/Hours per Week
_____	_____

How would you describe your relationship with your employer? _____
_____
_____

How would you describe your relationship with your work peers?_____
_____
_____

Mother: Living___ Deceased___ Married___ Divorced____
Remarried___(___# of times)
Describe relationship with mother while growing up:_____
_____
_____
Describe current relationship with mother: _____
_____
_____
Father: Living___ Deceased____ Married____ Divorced____
Remarried ___(___#of times)
Describe relationship with father while growing up: _____
_____
_____
Describe current relationship with father:_____
_____
_____
Where do your parents currently live?
Mother_____
Father_____
Please list your brothers and sisters:

Name	Age	Natural/Step	Lives Where?	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Marital History: Current status: ___Married ___ Divorced ___Widowed ___Never been married
If married, how long have you been married?_____ Spouses Name:_____
How many times have you been married?_____
If living with someone, how long have you lived together?_____
Please list your children:

Name	Age	Natural/Step	Lives With	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Others living in the home with you:

Name	Relationship	Age	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____

Mental Status: Please circle any of the following that describe how you have been feeling lately:
sad anxious depressed frightened guilty angry ashamed aggressive resentful
worthless tearful irritable confused extreme ups &downs jealous hopeless helpless

Describe any other feelings you have had:_____
_____
_____

Have you had any changes in sleeping habits? Yes___ No___
Describe:_____
_____
Have you had any changes in eating habits? Yes___ No___
Describe:_____
_____

Have you ever considered suicide in connection to your current problems?Yes___ No___
If so, please give a brief description with dates:

Description	Dates
_____	_____
_____	_____

Have you ever considered suicide in the past? Yes___ No___
Have you attempted suicide recently or in the past? Yes___ No___
If so, please give a brief description with dates:

Description	Dates
_____	_____
_____	_____

Level of functioning: List or describe any current impediments or problems in daily psychological, social or occupational functioning, i.e. isolation from friends/family, significant difficulty getting to work or making yourself do daily tasks, severe financial strain, recent divorce, loss or separation from family or friend, problems with supervisor, etc._____
_____
_____

Thoughts: Please check any of the following that apply to you:
___ I sometimes hear voices even though no one nearby is talking to me.
___ I sometimes feel that forces outside of me control me.
___ I sometimes feel that other people control my thoughts.
___ I sometimes have the same thought over and over and cannot control it.
___ I sometimes feel that someone is out to hurt me or do something against me.
___ I am sometimes unable to control my behavior. Please explain:_____
_____
_____

Please check coping skills that you are currently using: ___exercise ___relaxation ___prayer/meditation ___music ___reading ___hobby:_____ ___ church ___organization/clubs ___volunteering: _____ Please describe any spiritual orientation or belief (i.e. Christian, attend Catholic Church weekly):
_____
_____