Application and History for Adult

Please print clearly. Complete as much information as possible. This information will be discussed with your counselor.

Today's Date:_____

First Name:_____**Middle Initial**:_____

Last Name:_____

DOB:_____ **Age**._____

Social Security Number: _____

Address:_____Apt#_____Bldg#_____

_____

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

Home Phone:_____**Business Phone:** _____

Cell Phone:_____ **Email**:_____

May we leave a message on your voicemail: At Home: Yes No **On Cell:** Yes No
(Please Circle One)

Gender: M F

Race: Black Asian Biracial Hispanic White

Ethnicity: Non-Hispanic Haitian Hispanic Other _____

Marital Status: Single Divorced Married Separated Widowed

Religion: Christian Jewish Muslim Other_____

Employment Status: Employed full time Not employed Employed part-time

Retired Student

Primary Language: English Creole Russian Spanish Other_____
Live with: Adult child Parents Father only Group Home Alone

Mother only Other Significant Other Spouse

Non-home setting: Alf/nursing home Group Home Other

Gross Annual Family Income:_____

Total Adults in Home:_____ Total Children in Home:_____

Number of years of Education: _____

Relative/Significant Other/Neighbor:

Name:_____Relationship:_____
First Last
Address:_____
City State Zip

Phone Numbers: _____ _____ _____
Home Cell Office

In an emergency-Do they have a key to the home: Yes ___No___ D.O.B.:_____

Relative/Significant Other/Neighbor:

Name:_____Relationship:_____
First Last
Address:_____
City State Zip

Phone Numbers: _____ _____ _____
Home Cell Office

In an emergency-Do they have a key to the home: Yes ___No___ D.O.B.:_____

Relative/Significant Other/Neighbor:

Name:_____Relationship:_____
First Last
Address:_____
City State Zip

Phone Numbers: _____ _____ _____
Home Cell Office

In an emergency-Do they have a key to the home? Yes ___No___ D.O.B.:____

Client's Name: Click here to enter text. Date of Birth:Click here to enter text. Date:Click here to enter text.

Please describe reasons for seeking help

1.

2.

3.

4.

History of Presenting Problem:

Date of Onset: _____

Additional Complaints:

Sleep: ☐ Normal Click here to enter text. # of hours of sleep ☐ Difficulty falling asleep

☐ Frequent awakening Click here to enter text. Average time it takes to return to sleep

Appetite/Eating Behavior: ☐ Good/non problematic ☐ Increased ☐ Decreased

☐ Overeating ☐ Bingeing ☐ Anorexic Approximate weight change in past 4 months
☐Purge behaviors ☐ Vomiting ☐ Laxative ☐ Diuretic ☐ Excessive exercise

Symptoms of Depression: ☐ None ☐ Sad/depressed mood ☐ Reduced energy/fatigue

☐ Lack of motivation ☐ Change in Appetite ☐ Reduced libido ☐ Isolation ☐ Negativity

☐ Motor retardation ☐ Disturbance in sleep ☐ Absence of or reduction in pleasure

☐ Feeling of helplessness and/or hopelessness ☐ Suicidal thoughts

☐ Concentration problem ☐ Agitation/Irritability

Symptoms of Anxiety: ☐ None ☐ Chest Pains ☐ Cold Hands ☐ Dizziness ☐ Dry Mouth

☐ G-I Symptoms ☐ Spasms/Twitching ☐ Palpitations/Rapid heartbeat

☐ Shortness of Breath ☐ Constant Worry ☐ Frequent worry ☐ Panic

☐ Racing thoughts ☐headaches ☐ out of body sensations ☐ Specific fears _____

History of Violence: ☐ None ☐ Self-injuries ☐ Injury to others ☐ Property

☐ Destruction ☐Murder/Attempted murder ☐Domestic/ other violence/threat of violence

Are you currently or have you recently been involved in an abusive relationship:

Physical: ☐ Yes ☐ No Verbal: ☐ Yes ☐ No Emotional: ☐ Yes ☐ No

Sexual: ☐ Yes ☐ No

Substance Use/Legal History:

Have you ever been arrested or convicted of a crime? ☐ Yes ☐ No

Have you or anyone else ever suggested that you had problems as a result of your drinking or other substance use? ☐ Yes ☐ No

Have you ever found yourself unable to remember what happened during a time when you were drinking or using another substance? ☐ Yes ☐ No

Have you ever taken a drink or used a drug, not prescribed by your physician to help you feel better? ☐ Yes ☐ No

Have you ever received treatment or counseling for any alcohol or substance use related problem? ☐ Yes: ☐ No

Have you ever made an effort to stop or control your use of alcohol or other substance?

☐ Yes ☐ No

Have you ever attended a meeting of Alcoholics Anonymous (AA) Narcotics Anonymous (NA) or other twelve step self-help group? ☐ Yes: ☐ No

Please List below any alcohol or drugs that you currently use or have used in past

Substance	Age at 1st Use	Years of Use	Frequency	Amount

Please check any symptoms that you have experienced related to substance use:

☐ Blackouts ☐ Seizures ☐Increased Tolerance ☐ Legal Problems ☐Loss of Control

☐ Family Problems ☐Tremors ☐ Weight Change ☐Medical Problems ☐Impaired Memory

☐ Work/School Problems ☐Financial Problems ☐ Other

Is there a family history of substance abuse ___Yes ___No

If yes, please describe relationships, substances used, using/recovery status

Medical Information

Physicians	**Specialty**	**Phone #**

Medications

Please list any medications/ supplements/vitamins/ or over the counter prescriptions that you are taking. Please attach additional paper if needed.

Medications/ Supplements/ Vitamins/ Over the counter preparations	Amount	Frequency

Are you currently receiving any other form of counseling? Yes No

If yes, with whom?

Have you seen a psychiatrist or other counselors in the past? Yes No

If yes, with whom?

Have you ever been hospitalized for Mental Health Problems? Yes No

If yes, when and where?

Relevant Family Information:

Marital Status:

# of Prior Marriages:

# of children:

Who are the members of your current household? (include ages and relationship)

If your spouse and/or children are not listed above, what are their names, ages, and location?

_____
_____
_____

Describe your current family relationships

_____
_____
_____

Describe your childhood experiences and family relationships

_____
_____
_____
_____

What do you like to do for fun?

_____
_____
_____

What are your hobbies?

_____
_____
_____

What are your strengths?

_____
_____
_____

Clinician's Signature: _____ Date: _____