Lindsey Kremmel, PhD

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Adult History Form

Today's Date: _____

Name: _____ Preferred Name (if different): _____

DOB: _____ Age: _____ Gender: _____ Gender Pronouns (she/he/they…): _____

Sexual Orientation: { } Heterosexual { } Gay/Lesbian { } Bisexual { } _____

Relationship Status: { } Married { } Divorced { } Single { } Widowed
{ } Unmarried Long-Term Relationship

Race/Ethnicity: { } Caucasian { } African American/Black { } Asian Indian
{ } Asian { } Native American { } Hispanic/Latino/a
{ } Native Hawaiian/Pacific Islander { } _____

Education Level: { } Grade School { } High School { } College
{ } Professional/Trade School { } Graduate School

Occupation: _____ Employer: _____

Contact Information:
Address: _____ City: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

Therapist may leave a detailed message at: { } Home { } Work { } Cell { } Email

Living Situation: List all of the people who currently live with you

Name	Relationship	Age	Occupation/School Grade

Emergency contact person:

Name: _____ Relationship: _____ Phone #: _____

Referred by (How did you hear about my practice?): _____

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Main problem/major reason for seeking help at this time and how long you've been having this problem:

_____

_____

_____

Describe any other problems you are currently having:

_____

_____

Describe the impact of these problems in your life (relationships, work, etc):

_____

_____

What have you already tried to resolve these problems?

_____

_____

Briefly describe *past* and *current* psychological treatment including psychotherapy, medication, testing:

Dates	Facility/Therapist/Doctor	Reason for Treatment	Helpful? (Yes/No)

Have you had inpatient (stayed in the hospital) mental health treatment? { } Yes { } No
Have you *ever* attempted suicide? { } Yes { } No
Are you *currently* having thoughts or planning to harm yourself/suicide? { } Yes { } No
Are you *currently* having thoughts or planning to seriously harm someone else? { } Yes { } No
Do you have a history of abuse (physical, sexual, emotional, neglect)? { } Yes { } No
Is anyone *currently* hitting, insulting, threatening, or slapping you? { } Yes { } No
Is there legal action affecting you? { } Yes { } No

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Are you currently taking any medications? { } Yes { } No If yes, include the following information:

Name of Medication	Dosage	Prescribed by	Date Started

Are you currently under the care of a physician for any serious medical conditions? { } Yes { } No

If yes: Doctor's Name: _____ Treatment for: _____

Indicate if any family members or relatives have the following problems:

Problem:	Family member (mom, dad, sister, uncle, etc):
Depression	
Bipolar Disorder (Manic-Depressive)	
Nervous disorders/Anxiety	
Alcohol/Drug Problems	
Learning disabilities/delays	
Problems with attention or hyperactivity (ADHD)	
Autism/Asperger's	
Other Mental Health Problem: _____	
Serious illness: _____	
Other problems: _____	

What are your support systems? (church, friends, clubs etc.) _____

What are your strengths? _____

Additional information you want me to know:

_____

_____