Deerfield Township Family Counseling Center, LLC
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Adult History

Name: _____ **Date:** _____

CURRENT SITUATION **(presenting problem(s), precipitant(s), recent major stresses or life changes)**

_____
_____
_____
_____

HEALTH AND WELLNESS HISTORY

Primary Care Physician: _____Date of Last Visit to Physician: _____

Date of Last Physical:_____ Insurance: _____

Please describe what you do to relax or take care of yourself: _____

Do you exercise? □Yes □ No If yes, how many times per week? _____ Intensity: □High □Medium □Low

Height _____ Weight _____ Do you have any drug/food allergies? □Yes □ No If yes, please specify.

_____
_____Do you have any physical health problem(s)? □Yes □ No If yes, what condition(s)? _____
_____
_____

How would you describe the nutritional value and balance of your diet: □Excellent □ Good □ Fair □ Poor
Have you had significant appetite change over the past month? □Yes □No

Comments: _____

Have you had any weight change in the past 6 months? □ Yes □ No If yes, amount +/- _____

Comments: _____

Have you experienced any sleep disturbance in the past month? □Yes □ No

Comments: _____

Are you **currently** on any prescriptions, "over the counter" vitamins, herbs, supplements for anxiety, depression, mental health conditions or other medical conditions? □Yes □ No If yes, list all medications:

Medication/Purpose: _____ _____

In the **past,** have you taken any medication for anxiety, depression or mental health condition? □ Yes □No If yes, list all medications: _____ _____

Are you having any problems or concerns with your sexual functioning? □Yes □ No

Comments: _____

Name:_____

BEHAVIORAL HEALTH

Have you had prior mental health services, counseling, or alcohol/drug treatment? **☐Yes ☐No**

If Yes, please list names and dates below.

Out Patient		Inpatient	
Therapist or Program Name	Date	Hospital	Date

Regarding past or current treatment, what have you found most helpful? What has not been particularly helpful or effective? _____

_____

Have you ever experienced:

Physical abuse	☐Yes ☐ No	Domestic violence	**☐Yes ☐No**
Sexual abuse	☐Yes ☐ No	Emotional abuse	**☐Yes ☐No**
Rape/sexual assault	☐Yes ☐No	Other significant trauma	**☐Yes ☐No**

If Yes to any of the above explain:

_____

_____

_____

Are you now or have you in the past experienced any suicidal feelings/behavior? ☐Yes ☐ No If yes, please describe._____

_____

Do you have any history of violent/aggressive behavior? ☐Yes ☐No If yes, please describe below

_____

_____

Are you having difficulty with any activities of daily living? ☐Yes ☐No

If yes, indicate with which activities the client requires assistance from another person:

☐ Grooming/hygiene	☐ Homemaking	☐ Mobility	☐ Leisure Skills
☐ Bathing	☐ Shopping	☐ Transportation	☐ Time Management
☐ Dressing	☐ Banking	☐ Communication	☐ Stress Management
☐ Cooking	☐ Budgeting	☐ Child Care	☐ Other _____

Describe any recent difficulties:_____

_____

Adult History

Name:_____

CULTURAL/ETHNIC/SPIRITUAL

Cultural/ethnic/racial issues that need consideration? □ Yes □ No

If Yes, explain:_____

_____

Sexual Orientation issues that need consideration? □ Yes □ No

If Yes, explain:_____

_____

Religious/spiritual issues that need consideration? □ Yes □ No

If Yes, explain:_____

_____

FAMILY/CURRENT LIVING SITUATION

List household members:

Name	Age	Relationship to client

List children not residing in the home:

Name	Age	Living Arrangements

Describe any concerns about family members:_____

_____

_____

Is there any history of emotional or mental problems in the family? □ Yes □ No

If Yes, explain:_____

_____

Name:_____

MILITARY SERVICE □ Yes □ No

If Yes, Type of Discharge:_____

Were you involved in combat duty? □ Yes □ No

If Yes, please describe combat situation: _____

EMPLOYMENT

□ Full-time □Part-time □Unemployed Since _____ □Student

□ Homemaker □Volunteer □Retired Since _____ □Disabled Since_____

How long at current job?_____ How long at last job?_____

Are you having any problems at your workplace? □Yes □ No

If Yes, describe: _____

_____

FINANCIAL

Are you having financial problems? □Yes □ No

If Yes, please describe:_____

_____

LEGAL

Have you ever had involvement with the legal system? □Yes □ No

If Yes, explain when, what involvement, and the outcome: _____

_____

Do you have any current pending legal charges? □Yes □No

If Yes, explain:_____

Are you on probation or parole? □Yes □ No

If Yes, list PO's name and contact information: _____

_____

Have you ever been incarcerated (in jail)? □Yes □ No

If Yes, explain: _____

Name:_____

ALCOHOL AND DRUG USEAGE

Do you smoke cigarettes or use tobacco in any other form? □Yes □ No

If yes, describe (how often, how much):_____

Do you drink alcohol? □Yes □ No

If yes, describe (how often, how much):_____

Have you ever had concerns about your use of alcohol, prescription medications, or other drugs? □Yes □ No

If yes, what were your concerns?_____

_____

Has anyone else expressed concerns about your use of alcohol, prescription medications or other drugs? □Yes □ No

If yes, who was concerned and what were their concerns?_____

_____

Have you ever made a decision to cut down or quit using alcohol and/or other drugs? □Yes □ No

If yes, what made you decide to cut down or quit and what was the outcome of your efforts to cut down or quit?

_____

_____

Have you ever experienced any of the following in connection with your use of alcohol, prescription medications, or other drugs?

□Yes □ No	Financial Problems	□Yes □ No	Relationship Problems
□Yes □ No	Work Problems	□Yes □ No	Increased Tolerance
□Yes □ No	Physical Problems	□Yes □ No	Emotional Problems
□Yes □ No	Blackouts	□Yes □ No	Withdrawal Symptoms
□Yes □ No	Cravings	□Yes □ No	Legal

Has anyone in your family ever had problems with alcohol or other drug use? □Yes □ No

If yes, describe:_____

_____

Client's signature	Date
Reviewed/completed by Clinician	Date
Reviewed/updated by clinician	Date