Your Family Therapist
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ADULT INFORMATION FORM

Name_____ Date _____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

Address _____City _____State _____Zip_____

Home Phone _____ Cell Phone _____ Ok to leave message? Yes ____ No ____

E-mail Address _____ Ok to contact by e-mail? Yes ___ No ____

Emergency Contact _____ Phone Number _____

Who Referred _____ Can we thank them? Yes ____ No ____

Responsible Party Subscriber_____ Subscriber Date of Birth _____

Employer_____

Insurance Carrier _____ Subscriber No. _____ Group No._____

Co-Pay Amount _____ Deductible Amount _____ Is Your Deductible Met? Yes ____ No ____

If you have arranged in advance with your therapist to bill insurance please sign the release below:

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the supplier for services rendered.

Signed: _____ **Date:** _____

Reasons for seeking therapy

_____

_____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken:

1)_____ Dosage/Freq_____ Start Date_____Purpose_____

2)_____ Dosage/Freq _____ Start Date_____Purpose_____

3)_____ Dosage/Freq _____ Start Date_____Purpose_____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES / NO If no, have you used previously? (Circle One) YES / NO

If yes, when did you stop? _____

Type of Drug Used	How much	How often
_____	_____	_____
_____	_____	_____

Do you drink caffeine? (Circle One) YES / NO Do you have pets? (Circle One) YES / NO Type: _____

Do you drink alcohol? (Circle One) YES / NO If no, did you drink previously? (Circle one) YES / NO

If yes, please list:

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

Do you smoke cigarettes? (Circle One) YES / NO

Do you use other forms of tobacco? (Circle One) YES / NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience:_____

_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

_____

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

_____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain:_____

_____

What was the last year of school you completed? _____ If you did not complete high school, please explain:

_____

Please list schools you are currently attending, last attended, or that you have graduated from:

(1) School(s)_____ Year(s)_____

(2) School(s)_____ Year(s)_____

How would you describe your current support network? (friends, relatives, etc.): _____

_____

Please check all information, which applies to your biological parents:

MOTHER	FATHER
____ living	____ living
____ deceased	____ deceased
____ married	____ married
____ divorced	____ divorced
____ remarried ____# of times	____ remarried ____# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

_____

Where do your parents live? Mother _____

Father _____

Describe your relationship with your mother while growing up:_____

_____

Currently: _____

Describe your relationship with your father while growing up: _____

_____

Currently: _____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems, which occurred while growing up relating to:

Alcohol/drug abuse: _____

_____

Sexual/physical/emotional abuse:_____

_____

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check 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:_____

_____

What activities or hobbies do you participate in? _____

_____

Do you participate in regular exercise? (Circle One) YES NO Describe:_____

Describe your current working environment: _____

_____

Have you had any change in sleeping habits? (Circle One) YES NO Describe:_____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain:_____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain:_____

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 completing daily tasks, severe financial strain, recent divorce, or 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:_____

_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

Please list your therapy goals:

_____

_____

Notification and Acknowledgement of Notice of Privacy Practices Regarding Protected Health Information

Our Notice of Privacy Practices provides detailed information about how we may use and disclose protected health information about you. As a patient you have a right to a copy of that Notice. We reserve the right to change the Notice, and if we do, you may obtain a copy of the revised Notice from the same location[s] noted on our Privacy Practices Handout. Please acknowledge your receipt of this notification by signing below.

Responsible Party Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____