

Adult Application Form

I. General Information:

Date: _____

Referral Source:

How did you hear about me? Another Professional (please indicate) _____ Internet Search
(General) ___ Word of Mouth ___ Other: _____

Your First Name: _____ Last Name: _____

MI: _____ Preferred Name: _____ Gender: M ___ F ___

Social Security #: _____ Age: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Ethnicity/national origin: _____ Or other similar way you identify yourself and consider important

Occupation: _____ Employer: _____

If presently unemployed, describe the situation: _____

Are you a student? No (Please skip to next section) ___ Yes ___

How many credits are you currently taking? _____ What is your GPA? _____

What year are you currently enrolled in? Freshman ___ Sophomore ___ Junior ___ Senior ___ Graduate Student ___

Major / Specialization: _____

Are you a transfer student? Yes ___ No ___

Military Experience:

Have you ever been, or are you currently, enlisted in any branch of the US military (active duty, veteran, national guard or reserves)? Yes ___ No ___

In what capacity did you serve? _____

Did your military experiences include any traumatic or highly stressful experiences that continue to bother you (e.g., war, combat, injuries, death, foreign deployment, etc.)? Yes ___ No ___

Your family-of-origin: Name Current age (or age of death) Illnesses Occupation

Father

Mother

Brothers

Sisters

Stepparents

Grandparents

Uncles/aunts

Marital/relationship history:

Your Current Relationship Status: engaged__ married__ partnered__ common-law marriage__ separated__ remarried__ divorced__ "commuter marriage"__ other__

Spouse's/boyfriend's name	Spouse's age at marriage	Your age at marriage	Your age when you divorced
First			
Second			
Third			

Children: (Indicate those from previous marriage or relationship with "P" in the last column. Indicate stepchildren with "S".)

Name	Current Age	Sex	Grade	Adjustment problems?	P? S?
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Are you currently involved in any divorce or child custody proceedings? Yes__No__
 With whom are you currently living? Alone__ With Family (specify with whom):_____
 Roommates__Dorm__Other:_____

In case of emergency, contact:_____

Relationship:_____	Emergency phone:_____
	Preferred
	OK to leave message?

Your cell phone: _____	_____	_____
Your home phone: _____	_____	_____
Your work phone: _____	_____	_____
Other phone: _____	_____	_____

II. Medical History:

Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, convulsions/seizures, and any other medical conditions you have had:_____

Do you identify as having a disability? No__Yes__ (Please Specify):_____

Describe any allergies you have and allergy medications you take: _____

Are you now under a doctor's care?_____ If yes, name of your doctor:_____

Reason for the doctor's care _____

Are you taking any medications?_____ If yes, list names including prescribed, over-the-counter medications, vitamins, supplements, herbs, and others.

Medication	Dosage	Frequency	Date Started	Physician who Rx.	Side Effects	Effectiveness

Have you done any kind of work where you were exposed to toxic chemicals? _____

What kind of physical exercise do you get? _____

Do you try to restrict your eating in any way? _____

Do you have any problems getting enough sleep? _____

What percentage of time during the day (at home or at your job away from home) do you spend?
 Under normal stress load: _____ % Under considerable stress: _____ % Resting or relaxed:
 _____ %

Are there any other medical or physical problems you are concerned about? _____

For women only

At what age did you start to menstruate (get your period): _____

Menstrual period experiences (how regular, heavy, long they are, etc): _____

Please list all of your pregnancies (your age, problems?): _____

If your menopause has started, at what age did it start? _____

What signs or symptoms have you had? _____

III. Mental History:

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

If yes, please indicate (when, from whom, for what, with what results): _____

Have you ever taken medications for psychiatric or emotional problems? _____ If yes, please indicate (when, which medications, for what, with what results): _____

Do your mood and/or energy levels shift drastically from time to time? _____

Are you easily annoyed by other people? ____ Are you angry at anyone? ____ Do you keep your feelings to yourself? ____

Are you thinking of hurting anyone? ____ Have you ever tried to hurt yourself or worse? ____ If yes, please explain: _____

Abuse History:

Have you ever been violent and abusive toward others? ____ If yes, please explain: _____

Which is true? I was not abused in any way ____ I was abused ____ If you were abused, please indicate the following: For kind of abuse, use these letters: P=Physical, such as beatings; S=Sexual, such as touching/molesting, fondling, or intercourse; N=Neglect, such as failure to feed, shelter, or protect; E=Emotional, such as humiliation, etc.

Abuse By whom? Effects on you? Whom did you tell? Consequences of telling? Age

Your Sexual Orientation:

Heterosexual ____ Bisexual ____ Homosexual ____ Transgender ____ Questioning ____ Fluid ____

Legal history

Are you presently suing anyone or thinking of suing anyone? ____ If yes, please explain: _____

Have you ever been arrested? ____ On probation or parole? _____

Are you required by a court, the police, or a probation/parole officer to have this appointment? ____ If yes, please explain: _____

Chemical use

How many cups of regular coffee do you drink each day? _____ How many cups of tea? _____ How many sodas with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, etc)? _____ How many "energy drinks"? _____

How many cigarettes/cigars/other do you smoke per day? _____

Have you ever felt the need to cut down on your drinking? _____

How much beer, wine, or hard liquor do you consume each week, on the average? _____

Are there times when you drink to unconsciousness, or run out of money as a result of drinking? _____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you use them, their effects: _____

Relationships in your family-of-origin

Your parents' relationship with each other: _____

Your relationship with each parent and with any other adults present: _____

Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties: _____

Your relationship with your brothers and sisters, in the past and present: _____

Present relationships

How do you get along with your present spouse or partner? _____

How do you get along with your children? _____

Your important friends, past and present: _____

Your Strengths:

List five things you like about yourself: _____

List the people, activities, hobbies, groups that are supportive to you: _____

Your Religious affiliation: Protestant__ Catholic__ Jewish__ Islamic__ Buddhist__ Other (specify): _____

To what extent does your religious or spiritual preference play an important role in your life? Very Important__ Important__ Neutral__ Unimportant__ Very unimportant__

Which (if any) church, synagogue, or meeting are you involved with? _____

IV. Problem History:

What is the problem, in your own words? How do you see the situation? _____

How long has this been a problem for you? _____

What caused the problem to get worse? _____

Have you tried to solve this problem before? _____ If yes, please describe your previous attempts: _____

Other issues? _____

Recent significant stressors and life-cycle changes (e.g., new job, move, child leaving home, etc): _____

Why help is being sought *now*? _____

What are Your Goals for Counseling?

1. _____

2. _____

3. _____

Is there anything we haven't talked about that is relevant or important, or that you feel I should know about?

What types of counseling services would you prefer? (circle all that apply)

INDIVIDUAL FAMILY COUPLE/MARITAL SKILLS-DEVELOPMENT

OFFICE-BASED SCHOOL-BASED HOME-COMMUNITY BASED

Thank you for taking the time to complete the form! This information will help me understand your situation better and will allow us to assist you in reaching your goals as quickly as possible.