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Adult Clinical Information Form

As your psychologist this form will provide me with important information that will be useful in beginning to understand how I may be of help to you.

Today's date:_____

This form filled out by: (please print your full name)

_____

Relationship to the patient:

_____

Please complete all items that are pertinent:

Identifying Data

Patient's full name:_____

Date of birth:_____ Age:_____

Occupation: _____

Address: _____

_____

Phone: _____

E-mail address: _____

Members of your current household:

Name:_____ Age:_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list additional household members on the back of this page.

If you are part of a blended family or if divorced and have children, how has custody been arranged?

_____

_____

_____

_____

How many years of formal education have you completed?

_____

What degrees have you completed and in what year did you graduate?

_____

Please list other degrees, certifications or professional licenses.

_____

Reason for Referral

Who referred you?

_____

What is the problem or symptoms that concern you?

_____

_____

_____

_____

When did you first become concerned about this problem?_____

_____

_____

What changes would you like to see in yourself and your primary relationships?

_____

_____

_____

_____

Please check any of the following which currently apply:

Headaches	____	Feel bad about self	_____
Dizziness	____	Worried about sexual matters	_____
Fainting spells	____	Feel like your living in a dreamlike or	
Fast heartbeat	____	separate world	_____
Rashes	____	Feel out of touch with	
Stomach trouble	____	reality	_____
No appetite	____	Hear voices others do not hear	_____
Overweight	____	Have few or no friends	_____
Weigh loss	____	Withdrawn	_____
Sleep problems	____	Shy	_____
Nightmares	____	Difficulty controlling anger	_____
Aggressive behavior	____	Feel tense	_____
Lie for no reason	____	Mind wonders	_____
Fearful	____	Worried a lot	_____
Easily frustrated	____	Can't sit still	_____
Feel panicky	____	Feel like your always	
Sadness	____	on the go	_____
Difficulty making decisions	____	Short attention span	_____
Frequently feel guilty	____	Drink alcohol too much	_____
Thinks about hurting self	____	Friends worried about your	
Suicidal behavior		drinking	_____
or plans	____	Other drug use	_____

Homicidal feelings	____		
Feel lonely	____	Problems with work or career	_____
Feel hopeless	____	Financial problems	_____
Can't get your mind off certain thoughts	____	Feel others are out to get you	_____

Treatment History

Please indicate your previous history of treatment for behavioral, emotional or problems related to your psychological well-being. In addition, if you are currently working with another professional, agency or organizations please list them below.

1._____

2._____

3._____

4._____

Please, briefly describe your previous treatment as well as the issue that was addressed in counseling or therapy. Was it helpful?

_____

_____

_____

_____

FAMILY MEDICAL AND PSYCHIATRIC HISTORY

Please describe your family's neurological and psychological history.

_____

_____

_____

_____

_____

_____

_____

Does your family have a history of suicide? If so, please describe.

_____

_____

_____

_____

Is there a history in your family of learning disabilities, mood disorders, anxiety disorders, attention deficit/hyperactivity disorders or thought disorders? Please describe:

_____

_____

_____

_____

_____

_____

Please describe any significant medical problems from your past or that you are currently experiencing:

_____

_____

_____

_____

_____

Date of your last physical examination: _____
Your physician: _____

Physician's phone number: _____

Prescribed medications and dosage: _____

_____

_____

Please indicate any significant events that have occurred within your family that may have been particularly upsetting or have had a significant impact on your psychological well-being. Please include such events as separation or divorce, death of family members or close relatives, moving to new house or community, job loss, financial problems, criminal or legal problems involving family members.

_____

_____

_____

_____

_____

_____

Do you have any special interests or hobbies?

_____

_____

_____

_____