Margaret H. Anderson, PsyD
ADULT INFORMATION FORM

Name: _____ Date: _____
Address: _____ Gender: M__◯__F__◯__ Age: ___
_____ Date of Birth: _____
City: _____ State: _____ Zip: _____

Client number: _____ SSN: _____
Employer group of Insured Person: _____

CONTACT TELEPHONE NUMBERS

Please complete relevant information and indicate the number at which you wish to be contacted first.

PHONE NUMBERS	**OK** to leave Messages? YES	NO	**Primary contact** number?
HOME: _____	◯	◯	◯
WORK: _____	◯	◯	◯
CELL: _____	◯	◯	◯

MARITAL STATUS

__◯__ SINGLE __◯__DIVORCED (___) YRS __◯__ LIVING AS MARRIED (___) YRS
__◯__MARRIED (___) YRS __◯__SEPARATED (___) YRS __◯__WIDOWED (___) YRS

SPOUSE/PARTNER NAME: _____
If we are unable to reach you, is it OK to contact your spouse/partner? Yes__◯__ No__◯__
If yes, spouse/partner phone number: _____

EMPLOYMENT STATUS

Are you employed: __◯__ Yes __◯__No
Employer Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____
Address: _____
Phone: _____ Relationship to you: _____

PRIMARY CARE PHYSICIAN

Current Physician: _____
Physician Address: _____
Physician Phone Number: _____
Physician Fax Number: _____

REFERENT INFORMATION

BY WHOM WERE YOU REFERRED? _____
PHONE: _____ FAX: _____
PRESENTING PROBLEM: _____

ADULT INFORMATION FORM

Margaret H. Anderson, PsyD

Name: _____ Date: _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

Please check all of the behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Other:_____

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances

◯ Yes ◯ No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe: _____

◯ Yes ◯ No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

◯ Yes ◯ No Have you recently been physically hurt or threatened by someone else? If yes, please describe: _____

Therapist Notes:
Init: ____

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/partner			
Children			

Family Mental Health Problems	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

◯ Parents legally married or living together
◯ Parents temporarily separated
◯ Parents divorced or permanently separated

☐ Mother remarried: Number of times _____
☐ Father remarried: Number of times _____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

Therapist Notes:
Init: ____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
◯	◯	Outpatient Counseling			
◯	◯	Medication (mental health)			
◯	◯	Psychiatric Hospitalization			
◯	◯	Drug/Alcohol Treatment			
◯	◯	Self-help/Support Groups			

Therapist Notes:
Init: ____

Name: _____

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

◯ Yes ◯ No Have you had withdrawal symptoms when trying to stop using any substances? If yes, please describe: _____

◯ Yes ◯ No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe: _____

Therapist Notes:
Init: ____

MEDICAL INFORMATION

Date of last physical exam: _____

Have you experienced any of the following medical conditions during your lifetime?

☐ Allergies	☐ Asthma	☐ Headaches	☐ Stomach aches
☐ Chronic pain	☐ Surgery	☐ Serious accident	☐ Head injury
☐ Dizziness/fainting	☐ Meningitis	☐ Seizures	☐ Vision problems
☐ High fevers	☐ Diabetes	☐ Hearing problems	☐ Miscarriage
☐ Sexually transmitted disease	☐ Abortion	☐ Sleep disorder	☐ Other: _____

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

Allergies and/or adverse reactions to medications: ☐ None
If yes, please list: _____

Therapist Notes:
Init: ____

Name: _____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one? _____)

To which cultural or ethnic group do you belong? _____
If you are experiencing any difficulties due to cultural or ethnic issues, please describe:_____
_____

How important are spiritual matters to you? ◯ Not at all ◯ Little ◯ Somewhat ◯ Very much
◯ Yes ◯ No Would you like spiritual/religious beliefs to be incorporated into your counseling?

Please describe your strengths, skills, and talents? _____
_____
Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____
_____

Therapist Notes:
Init: ____

MISCELLANEOUS INFORMATION

Employment

Employer: _____ Position: _____
Length of time in this position: _____ Job Duties: _____
Stress level of this position: ◯ Low ◯ Medium ◯ High
Other jobs you have held: _____

Education

◯ Yes ◯ No Are you currently attending school?

☐ High School Graduate? Or ☐ GED? Year _____
☐ Associate's Degree Year _____ Major area of study _____
☐ Undergraduate Degree Year _____ Major area of study _____
☐ Graduate Degree Year _____ Major area of study _____

Military Service

◯ Yes ◯ No Have you been/are you currently in the military? (If no, skip remainder of this section)

Branch _____ Date of Discharge _____ Type of Discharge _____ Rank _____
◯ Yes ◯ No Were you in combat?

Legal

◯ Yes ◯ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain_____
_____
◯ Yes ◯ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain _____

Therapist Notes:
Init: ____