Family Counseling
& PSYCHOLOGY CENTER
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Adult Contact Information

Name: _____ Date:_____

Legal Name (if different): _____

Address: _____ Gender: M F TG

City: _____ State: _____ Zip: _____ Date of Birth: _____

Social Security #: _____-____-_____

Insurance Information

Primary Health Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: _____

ID Number: _____ Group/Policy #: _____

Type of Additional Coverage: ☐ Secondary ☐ EAP (Employee Assistance Program)

Additional Health Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: _____

ID Number: _____ Group/Policy #: _____

Contact Telephone Number

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

	Phone Message OK? YES	NO	Primary contact number	Appt. Reminder through
Home: ( ) _____-_____	☐	☐	☐	☐
Work: ( ) _____-_____	☐	☐	☐	☐
Cell: ( ) _____-_____	☐	☐	☐	☐

Email: _____ Ok to email ☐ YES ☐ NO

Name _____ D.O.B._____ ID#_____

Marital Status

☐ Single ☐ Divorced (____years) ☐ Living as Married (____years)

☐ Married (____years) ☐ Separated (____years) ☐ Widowed (____years)

Spouse's/Partner's Name: _____

If FCPC is unable to reach you, is it OK to contact your spouse/partner? ☐ YES ☐ NO

Employment Status

Are you employed? ☐ YES ☐ NO Are you using EAP? ☐ 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

By whom were you referred? _____

Name _____ D.O.B._____ ID#_____

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
- ☐ Concentration/forgetfulness
- ☐ Seasonal mood changes
- ☐ Sadness/depressed mood
- ☐ Unable to enjoy activities
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Decreased Libido
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic Attacks
- ☐ Avoidance
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Increased irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing Voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Increased Libido
- ☐ Decreased need for sleep
- ☐ Increased risky behavior
- ☐ 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
- ☐ Recurring, disturbing memories
- ☐ Viewing Pornography
- ☐ 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

Name _____ D.O.B._____ ID#_____

Yes No Have you ever had feelings or thoughts that you didn't want to live? If yes, please describe: _____

If yes to the above……

- How often do you have these thoughts? _____
- When was the last time you had these thoughts of dying? _____
- Has anything happened recently to make you feel this way? _____
- On a scale of 1 to 10 (ten being strongest) how strong is your desire to kill yourself currently? ____
- Would anything make it better? _____
- Have you ever thought about how you would kill yourself? _____
- Is the method you would use readily available? _____
- Have you planned a time for this? _____
- Is there anything that would stop you from killing yourself? _____
- Do you feel hopeless and/or worthless? _____
- Have you ever tried to kill or harm yourself before? _____
- Do you have access to guns? _____ If yes, please explain _____

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

Name _____ D.O.B._____ ID#_____

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

If yes to the above……

- How often do you have these thoughts? _____
- On a scale of 1 to 10 (ten being strongest) how strong is your desire to kill someone else currently?
- Have you ever thought about how you would kill someone else? _____
- Is the method you would use readily available? _____
- Have you planned a time for this? _____
- Do you feel hopeless and/or worthless? _____
- Have you ever tried to kill or harm someone else before? _____
- Do you have access to guns? _____ If yes, please explain _____

Therapist Notes:

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
- ☐ Place a child for adoption
- ☐ Lived in a foster home
- ☐ Multiple family moves
- ☐ Homelessness
- ☐ Loss of a loved one
- ☐ Financial problems
- ☐ Miscarriage/Stillborn

Name _____ D.O.B._____ ID#_____

Please note if any family members have experienced any of the following mental health problems.

Family Mental Health History	Who?
ADHD	
Experienced Sexual Abuse	
Depression	
Bipolar Disorder	
Made Suicide Attempt	
Anxiety Problems	
Panic Attacks	
Obsessive-Compulsive Behavior	
Anger Problem/Abusive Behavior	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	
Autism	
Self Harm Behavior	
Other	

Family Background and Childhood History:

- Were you adopted? ☐ Yes ☐ No
  - If Yes at what Age _____
- Where did you grow up? _____
- What was your father's occupation? _____
- What was your mother's occupation? _____
- Did your parents' divorce? ☐ Yes ☐ No If so, how old were you? _____
- If your parents' divorced, who did you live with? _____
- Describe your father, and your relationship with him: _____
  _____
  _____
- Describe your mother, and your relationship with her: _____
  _____
  _____
- How old were you when you left home? _____
- Has anyone in your immediate family died? _____ Who and when: _____
  _____

Name _____ D.O.B._____ ID#_____

Relationship History and Current Family:

Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed

How long: _____

If not married are you currently in a relationship? Yes No If yes, how long? _____

Are you sexually active? Yes No

How would you identify your sexual orientation?

☐ straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transsexual
☐ unsure/questioning ☐ asexual ☐ other ☐ prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____
_____

Have you had any prior marriages? Yes No If so, how many? _____ For how long? ____

Do you have children? Yes No If yes, list ages and gender: _____
_____

Describe your relationship with your children: _____
_____

List everyone who currently lives with you: _____
_____

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:

Name _____ D.O.B._____ ID#_____

Substance Use History

- Tobacco
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Caffeine
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Alcohol
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Marijuana
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Cocaine/Crack
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Ecstasy
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Heroin
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Inhalants
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Methamphetamines
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Pain Killers
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- PCP/LSD
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Steroids
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____
- Tranquilizers
  - Current Use (last 6 months) ☐ Yes ☐ No Frequency_____ Amount_____
  - Past Use ☐ Yes ☐ No Frequency_____ Amount_____

Name _____ D.O.B._____ ID#_____

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

Have you gambled in the past 6 months? ☐ Yes ☐ No If yes, let us know the following:
Have you ever felt the need to bet more and more money? ☐ Yes ☐ No
Have you ever had to lie to people important to you about how much you gambled? ☐ Yes ☐ No

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

Therapist Notes:

Medical Information

Date of last physical exam: _____

Personal and family medical history:

☐ Allergies
☐ Chronic Pain
☐ Dizziness/Fainting
☐ High fevers
☐ Sexually transmitted disease
☐ Obesity
☐ Asthma/respiratory problems
☐ Surgery
☐ Meningitis
☐ Diabetes
☐ Abortion
☐ Headaches
☐ Serious Accident
☐ Seizures
☐ Hearing problems
☐ Sleep disorder
☐ Stomach Aches
☐ Head injury/Trauma
☐ Vision problems
☐ Miscarriage
☐ Other: _____

Personal and Family Medical History:

	Yes	No	Which Family Member
Thyroid Disease			
Anemia			
Liver Disease			
Chronic Fatigue			
Kidney Disease			
Stomach or intestinal problems			
Cancer (type)			
Fibromyalgia			
Heart Disease			
Chronic Pain			
High Cholesterol			
High Blood Pressure			
Liver Problems			
Other			

Name _____ D.O.B._____ ID#_____

Please list any CURRENT health concerns: _____
_____
_____

Past medical problems, surgeries, or non psychiatric hospitalization: _____
_____
_____

Add additional personal or family history: _____
_____
_____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By	Taken For

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

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

Therapist Notes:

Interpersonal/Social/Cultural Information:

Please describe your social support network (check all that apply)

☐ Family ☐ Neighbors ☐ Support/Self-Help Group ☐ Friends ☐ Students

☐ Community Group ☐ Co-Workers ☐ 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: _____
_____

Name _____ D.O.B._____ ID#_____

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much

Would you like spiritual/religious beliefs to be incorporated into your counseling? ☐ Yes ☐ No

Please describe your strengths, skills, and talents? _____
_____
_____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _____
_____
_____

Therapist Notes:

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:

Are you currently attending school? ☐ Yes ☐ No

	Yes	No	Year Graduated	Major of Study	School Attended
High School Graduate					
GED					
Associate's Degree					
Undergraduate Degree					
Graduate Degree					

Name _____ D.O.B._____ ID#_____

Military Service:

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

Branch _____ Date of Discharge_____ Type of Discharge _____

Rank _____ Were you in combat? ☐ Yes ☐ No

Legal:

Have you ever been arrested? ☐ Yes ☐ No

Do you have any pending legal problems? ☐ Yes ☐ No

Have you ever been convicted of a misdemeanor or felony? ☐ Yes ☐ No If yes, please explain: ___
_____

Are you currently involved in any divorce or child custody proceedings? ☐ Yes ☐ No
If yes, please explain: _____

Therapist Notes:

Signature: _____ Date: _____