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# Client Information (Adult)

Today's Date: _____ Name: _____

## Demographic Information

Date of birth: _____ Age: _____ Sex: _____

Home street address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email: _____

People you live with (names, ages, relationships): _____

_____

_____

## Presenting Concerns

What are the difficulties that you brought you here? _____

_____

_____

_____

What do you hope to gain from treatment? _____

_____

_____

_____

## Medical Background

Date of last physical exam: _____

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List any medical conditions or allergies you have: _____

_____

_____

List any medications, including dosage and frequency, you are *currently* taking: _____

_____

_____

_____

## Education and Employment

Highest grade completed in school: _____ Year: _____ Major: _____

Employer: _____ For how long? _____

Position: _____

## Biological Family History

| | Name | Any history of mental illness? |
|---|---|---|
| Father: | _____ | _____ |
| Mother: | _____ | _____ |
| Sibling: | _____ | _____ |
| Sibling: | _____ | _____ |
| Other: | _____ | _____ |

## Prior Counseling

List all prior counseling, mental health treatment, or psychiatric hospitalizations: _____

_____

_____

_____

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What was the focus of treatment and what modalities were used (if known)?_____

_____

_____

Was treatment helpful? Why or why not?_____

_____

_____

## Other

Is there anything else that would be helpful to know? _____

_____

_____

_____

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## Symptom Checklist (Adult)

Please check each item that describes a symptom you have experienced to any significant degree during the last month.

| | Physical Symptoms |
|---|---|
| ☐ | Alcohol, cigarette, or drug use |
| ☐ | Allergies |
| ☐ | Appetite change |
| ☐ | Backaches |
| ☐ | Cold hands and/or feet |
| ☐ | Constipation |
| ☐ | Diarrhea |
| ☐ | Difficulty sleeping |
| ☐ | Fatigue, lack of energy |
| ☐ | Hair pulling |
| ☐ | Headaches [migraine or tension] |
| ☐ | Heart beats rapidly, even at rest |
| ☐ | High blood pressure |
| ☐ | Jaw tension |
| ☐ | Muscle cramps, spasms |
| ☐ | Nausea |
| ☐ | Neck and shoulder pain |
| ☐ | Nervous stomach |
| ☐ | Skin condition [e.g., rash] |
| ☐ | Skin picking |
| ☐ | Speech difficulties |
| ☐ | Stomach pain or ulcer |
| ☐ | Tics |
| ☐ | Tight muscles |
| ☐ | Tightness or pressure in the head |
| ☐ | Weight change |

| | Psychological Symptoms |
|---|---|
| ☐ | Anxiety |
| ☐ | Apathy |
| ☐ | Compulsive behavior |
| ☐ | Confusion |
| ☐ | Crying spells |
| ☐ | Delusions (false ideas) |
| ☐ | Difficulty concentrating |
| ☐ | Dissatisfied/unhappy with work |
| ☐ | Feeling overwhelmed |
| ☐ | Forgetfulness |
| ☐ | Frequent irritability/Low frustration |
| ☐ | Guilt |
| ☐ | Hyperactivity; feeling you can't slow down |
| ☐ | Impulsivity |
| ☐ | Intrusive, recurrent, unwanted thoughts |
| ☐ | Irrational fears |
| ☐ | Lack of motivation |
| ☐ | Legal difficulties |
| ☐ | Loneliness |
| ☐ | Low self-esteem |
| ☐ | Lying |
| ☐ | Mood swings |
| ☐ | Nightmares |
| ☐ | Relationship/social difficulties |
| ☐ | Sadness |
| ☐ | Self-harm |
| ☐ | Suicidal ideation |
| ☐ | Suspiciousness, distrust |

Other concerns: _____

_____

_____