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Adult Client Information Form 1

Today's date: ____/____/____

Note: If you were a patient here before, please fill in only the information that has changed.

A. Identification

Your legal name: _____ Date of birth: ____/____/____

Preferred name: _____

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

Preferred phone number: _____ Email: _____

May I leave a voice message for you? ❑ Yes ❑ No **Send a text?** ❑ Yes ❑ No **Email?** ❑ Yes ❑ No

❑ Disability status: _____ ❑ Talk about later

❑ Gender identity: _____ ❑ Talk about later

❑ Sexual orientation: _____ ❑ Talk about later

❑ Racial/ethnic identities: _____ ❑ Talk about later

❑ Religious/spiritual traditions or identity: _____ ❑ Talk about later

Other ways you identify yourself and consider important: _____

B. Emergency information

If some kind of emergency arises and we cannot reach you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

C. Referral

Who gave you my name to call? _____

Is this person's relationship with you ❑ personal or ❑ professional?

If professional, may I let this person know that you have come to see me? ❑ Yes ❑ No

D. Current problems or difficulties

Please describe the main difficulties that led to your coming to see me: _____

_____

_____

When did these problems start? _____

_____

_____

What makes these problems worse? _____

_____

What makes these problems better? _____

_____

With therapy, how long do you think it will take for these to get a lot better? _____

E. Treatment history

Have you ever received inpatient or outpatient psychological, psychiatric, drug/alcohol treatment, medications, or counseling services before? ❑ No ❑ Yes. If yes, please describe:

When (dates)?	For what (diagnosis)?	What kind of treatment?	Where or from whom?	With what results?

What medications, herbs, or supplements are you taking for mental, emotional, or psychiatric conditions?

Name of medication	For what condition?	Who prescribes this?	What have been the effects on you?

Are you currently self-harming? ❑ Yes ❑ No In the past: ❑ Yes ❑ No

Are you currently suicidal? ❑ Yes ❑ No In the past: ❑ Yes ❑ No

F. Chemical Use

1a. How many caffeine drinks (coffee, tea, colas, energy drinks, etc.) do you use each day? _____

1b. How often each week do you use medications (prescription or over-the-counter) or chemicals to be more alert or sharper? _____

2a. How much tobacco do you smoke or chew each week? Amount: _____ Kind: _____

2b. Do you use vapor or e-cigarettes? ❑ No ❑ Yes. How many per week? _____

3. How many drinks of beer, wine, or hard liquor do you consume in a typical week? _____

4. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

5. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

6. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

7. Have you ever taken a morning “eye-opener”? ❑ No ❑ Yes

8. Did you ever drink to unconsciousness, or run out of money because of drinking? ❑ No ❑ Yes
9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes. If yes, which and when? _____
10. Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

    _____
11. Do you think that you have a drug or alcohol problem? ❑ No ❑ Yes

G. Family-of-origin history

Which of the following best describes the family in which you grew up? ❑ Warm/accepting ❑ Average ❑ Hostile/fighting ❑ Other: _____

How did your family discipline you? _____

How did your family reward you? _____

How much time did your primary caregiver spend with you when you were a child? ❑ A lot ❑ Average ❑ Little

How did you get along with this person when you were a child? ❑ Poorly ❑ Average ❑ Well

How do you get along with this person now? ❑ Poorly ❑ Average ❑ Well ❑ Does not apply

Did this person have any problems (e.g., alcoholism, violence) that may have affected your childhood development? ❑ Yes ❑ No ❑ Don't know

Is or was there anything unusual about this relationship? ❑ No ❑ Yes: _____

Is or was there anything unusual about any familial relationship? ❑ No ❑ Yes: _____

H. Religious concerns

What role, if any, does faith or spirituality play in your life? _____

_____

What is your present religious affiliation, if any? _____

I. Other

Is there anything else that is important for me to know about, and that you have not written about on any of these forms? ❑ No ❑ Yes, and I have written about it below and/or on the back of this sheet.