ADULT CLIENT or PARENT'S HISTORY

Date:_____

Your Name _____ Age _____

Sex: M____ F____ Ethnicity_____ Marital Status _____

Date problem began : _____/_____/_____

Employer's Name: _____

Length of current employment: From (date) _____To (date) _____

FAMILY HISTORY:

Date of birth: _____/_____/_____
Month Day Year

Place of birth: City _____ State _____ Country _____

Upbringing was primarily by: Mother_____ Father_____ Both Parents _____

Other:_____

Mother living Yes_____ No _____

Relationship with your mother: Close _____ Distant _____ Hostile_____

Her current or past occupation:_____

City, State of residence: _____

Mother's health: Good _____ Fair _____ Poor _____

Describe nature of illness, if any:_____

Father living: Yes_____ No _____

Relationship with your father: Close _____ Distant _____ Hostile_____

His current or past occupation: _____

City, State of residence: _____

Father's health: Good _____ Fair _____ Poor _____

Describe nature of illness, if any: _____

If parents deceased,

Mother's age at death_____

Cause of death_____

Your age at the time_____

How well have you resolved the death?

Unresolved_____Moderately_____ Fully resolved_____

Father's age at death _____

Cause of death_____Your age at the time_____

How well have you resolved the death?

Unresolved_____Moderately_____ Fully resolved_____

EDUCATION:

Highest grade completed:_____
School last attended: _____
How well did you do in school? Good _____ Average _____ Poor_____
Degree or professional licenses? _____

MARRIAGE:

Current marital status: Single ___ Married ___ Divorced ____Separated ____ Widowed _____
Number of marriages, including present: _____
Current marriage date: _____
Quality of current marriage: Very Good _____ Average _____ Poor_____
Name of current spouse: _____Age _____ Occupation _____

If widowed:
Date of death:_____Spouse's age at death_____
Cause of death:_____Your age at the time_____
How well have you resolved the death?
Unresolved_____Moderately_____ Fully resolved_____

Are you involved in an exclusive, on-going relationship? Yes _____ No _____
If so, what is the quality of this relationship: Very good_____ Average_____ Poor _____
How long has this relationship lasted?_____
Your partner's age: _____Your partner's occupation:_____
Your partner's health: Good _____ Average _____ Poor _____
Number of children in the immediate family: _____

MILITARY HISTORY:

Branch of service: _____ Dates: From _____ To _____
Type of discharge: _____Highest Rank_____
Any service connected disability? Yes_____ No _____
Please explain _____

PERSONAL HABITS:

Tobacco use?	Yes _____	No _____
Coffee and/or tea use?	Yes _____	No _____
Alcohol use?	Yes _____	No _____
Have you ever been a heavy drinker?	Yes _____	No _____
Are you an alcoholic?	Yes _____	No _____
Ever arrested for intoxication?	Yes _____	No _____

Explain: (Give Dates) _____
_____

Do you use other drugs? Yes _____ No _____

Drug Type	Date Began	Frequency (Daily or Weekly)	Work Problems from drug use?
Marijuana			
Cocaine			
PCP			
Other			

Explain any work problems resulting from drug use and any changes in use due to them.

_____

_____

_____

_____

Are you taking any prescription medication? Yes_____ No_____
Name of medication(s): _____

_____

For what condition or problem?_____
Name of physician who prescribed medication:_____

MEDICAL/PSYCHIATRIC HISTORY:

Hospitalized for alcohol abuse? Yes _____ No _____
If so, please give the dates of hospitalization: _____
Name of Hospital or treatment setting:_____
City:_____

Hospitalized for drug use? Yes _____ No _____
If so, please give the dates of hospitalization: _____
Name of Hospital or treatment setting:_____
City:_____

Any psychiatric hospitalizations? Yes_____ No_____
Dates:_____
Hospital:_____
City:_____
Reasons:_____

Any other type of counseling? Yes_____ No_____
What kind of counseling?_____
Reasons:_____
Dates:_____

CHRONIC ILLNESS:

ILLNESS	DATE OF ONSET	MEDICATION TAKEN	BLOOD RELATIONS AFFECTED
Asthma			
Diabetes			
Epilepsy			
Arthritis			
High blood pressure			
Ulcers			
Others			

Other medical problems at any time in your life? Yes_____ No_____

Nature of problem(s)_____

_____

Your age at time of this problem/problems_____

_____

_____