9915 E. Bell Rd., Suite 120, Scottsdale, AZ 85260

Adult History Form

Date ____________________________

Referred by: Self Doctor Family Member

Your Name ____

Date of Birth _____________________ Age ________________

Address ____

City ______________________________ State ______________ Zip ______________________

Home Phone ____________________________________ Cell Phone ___________________________________

Okay to Leave a message on ________Home ________Cell

Email Address: ____

Name of Primary Care Doctor (if applicable) ____ Phone _________________________

Name of Psychiatrist (if applicable) ____ Phone _________________________

Demographic Information:

Ethnicity_________________________

Marital Status: Single_____ Married_____ Divorced_____ Separated_____ Widowed_____ Living Together_____

If currently in relationship, for how long?___________ Name of your partner_________________________________

Number of total marriages: _________

If divorced, what year did your divorce(s) finalize?_________________________

Occupation____________________________________ How long has this been your occupation?_________

Areas of concern--please check all that apply.

____	Feelings and thoughts about yourself	____	Health Issues	____	Depression or Sadness	____	Low Ambition or Motivation	____	Grief/Loss
____	Marital/Partner Issues	____	Work	____	Poor Sleeping	____	Thoughts of Suicide	____	Stress
____	Family Relationships	____	Age/Stage of Life struggles	____	Over/Under Eating	____	Nervous/Fearful	____	Alcohol/Drugs
____	Parenting Issues	____	Finances	____	Changes in Appetite	____	Anger or Irritability	____	Traumatic event(s)
____	Social Relationships	____	Low Energy/Fatigue	____	Poor Concentration	____	Anxiety/Panic	____	Sexual Problems

Any other area of concern not listed above? ____

Please explain all areas of concern checked above.

____

____

____

____

How long have these difficulties been a concern?

____

____

How do these difficulties affect you and/or your family?

____

____

Are you currently receiving help for these difficulties anywhere else? Where? Is it helpful?

____

____

What do you hope to accomplish by participating in counseling? How will you know if you are making progress?

____

____

Have you or anyone in your family received counseling in the past? When? Was it for related or different difficulties? Was it helpful?

____

____

Home/Family Information:

Please list all people who currently live with you.

Name	Age	Relationship to you

Do you have any children who do not live with you? ____________ If so, please provide name, age and where he/she resides:

____

____

Are any of your children from a relationship other than your current one?____

Is there anyone not present today that you would like included in future counseling sessions?

____

____

Are you dissatisfied with any aspects of your home/living environment? If so, please describe.

____

____

____

Health Information:

Do you have any general medical conditions or health problems? If so, are you receiving treatment?

____

____

Please list any medications you are currently taking.

____

____

____

Please list any past PSYCHOTROPIC (psychotherapeutic) medications that you have taken. Did the medication help?

____

____

____

Have you ever been hospitalized for psychiatric treatment? If so, when and where were you hospitalized?

Please list any immediate or extended family members who have suffered with mental illness or substance abuse.

Have you ever attempted suicide? If yes, please provide details.

Do you currently drink alcohol? Approximately how many drinks per week? Stop Date (if applicable)?

Do you currently use recreational drugs? What types? How often? Stop Date (if applicable)?

Have you ever been concerned about your use of alcohol or drugs?

Has someone else ever expressed concern about your alcohol or drug use?

Legal Information:

Are you currently involved in any civil or criminal legal proceedings?

Have you been involved in any criminal legal proceedings in the past?

Social, Spiritual and Cultural Information:

Who are your primary supports in life? Please include both formal (e.g., groups) and informal (e.g., friends, family).

Is there any information you would like to share regarding your cultural background or currently family culture?

Is there any information you would like to share regarding your spiritual/religious beliefs and practices or any other significant aspects of your life?