envision
COUNSELING

Adult History Form

This form is to be completed by the named individual. All information is considered confidential. If you have any questions please leave it blank until your session. If you need additional space please feel free to use the back and indicate with an arrow.

Name _____ Today's Date _____

Date of Birth _____ Age _____ Gender: M F

Address _____

Telephone/Email: Please indicate if it is okay to leave / send messages. **Remember that email is not considered a confidential form of communication.**

Home _____ Yes No Cell _____ Yes No

Work _____ Yes No Email _____ Yes No

Occupation _____ Employer _____

Person to contact in case of an emergency:

Name _____ Home phone _____ Cell _____

Address _____

Medical History:

Physician's Name _____ Phone _____ Date of last checkup _____

Psychiatrist's Name _____ Phone _____

How would you describe your overall health? Excellent Good Fair Poor

How would you describe your nutritional diet? Excellent Good Fair Poor

How would you describe your level of activity? Excellent Good Fair Poor

Symptom Checklist Adult

Check any symptoms that apply to you in the past month.

( ) Chronic sadness

( ) Crying episodes

( ) Hopelessness

( ) Difficulty concentrating

( ) Loss of appetite

( ) Overeating

( ) Nausea/Vomiting

( ) Difficulty making decisions

( ) Low energy/fatigue

( ) Agitation

( ) Restlessness

( ) Excessive worry

( ) Fearfulness

( ) Trembling/shaking

( ) Fear of loss of control

( ) Fear of dying

( ) Intrusive thoughts of bad memories

( ) Flashbacks/re-living bad experiences

( ) Hear voices others do not hear

( ) Fearful others are talking about me

( ) Difficulty completing tasks/distracted

( ) Difficulty focusing

( ) Tendency to act impulsively

( ) Not well organized

( ) Racing thoughts

( ) Excessive spending

( ) Aggressive/abusive toward others

( ) Previous Suicide Attempt

( ) Current thoughts of suicide

( ) Current thoughts of physically hurting others

( ) Sleep problems

( ) Memory problems

( ) Low frustration tolerance

( ) Isolating

( ) Reduced interest/pleasure in activities

( ) Panic attacks

( ) Fear of leaving home

( ) Avoidance of public places

( ) Avoidance of social situations

( ) Pounding heart/palpitations

( ) Shortness of breath

( ) Feeling detached from other/life

( ) Nightmares

( ) Easily startled/upset

( ) Seeing things others do not see

( ) Fearful someone is plotting against me

( ) Taking on too many tasks

( ) Frequent forgetfulness

( ) Difficult to wait my turn

( ) Problems with co-workers

( ) Problems in school growing up

( ) Hard to stay with a job very long

( ) Staying up for days without sleep

( ) Multiple sexual partners

( ) Confused/worried about sexual behavior

( ) Irritability

Current Medications:

Name of Medications	Dosage (mg)	Prescribing doctor and phone Number	Reason for medication	Date began

Have you ever received counseling? Yes No

Where, when, reasons, and what was the outcome? _____

_____

_____

What is your primary reason for seeking counseling? _____

_____

_____

What do you hope to accomplish through counseling? _____

_____

_____

Client Name (print) _____

Signature _____ Date _____