Adult History Form

Today's Date

Full Legal Name

Name you prefer

What is your current gender identity?

- Male
- Female
- Transgender Male/Transman/FTM
- Transgender Female/Transwoman/MTF
- Gender Queer
- Additional Category (Please Specifiy)

What sex were you assigned at birth (Check one)

- Male
- Female
- Other
- Decline to Answer

Address/Street & Apartment number

City State and Zip Code

Alternate preferred mailing address

Home Phone

Cell Phone

Work Phone

E-mail - no work mail please

Should I need to reach you to reschedule an appointment or to forward information, which is your method of contact? Please be sure the method is confidential.

- [ ] Home Phone
- [ ] Cell Phone
- [ ] Work Phone
- [ ] Personal Email
- [ ] Text Message

I understand that I am responsible for protecting my personal information sent by this office to clients on their devices. ☐ Yes

Are you employed? ◯ yes
◯ no

Name and Address of your employer

Describe your job duties.

Are you being referred by an Employee Assistance Program (EAP) ? ◯ yes

If yes, what is the name and phone number of your EAP company. ◯ no
Please this the authorization number for the appointments?

How many counseling sessions did they give you?

Which Primary Insurance company covers your regular mental/behavioral health services?

Phone number for Behavioral Health Service on the back of your insurance card.

Have you called your Insurance company to get pre-authorization for counseling?

- ◯ yes
- ◯ no

Social Security Number

Insurance policy number

Group policy number

Client Date of Birth

Policy Holder's Full Name and Date of birth

How did you learn about my practice?

In the event of an emergency, who do I have permission to contact?

Emergency contact phone number and relationship to you.

Please list names/ages/relationship of everyone living in your household.

List all the losses you have experienced such as deaths, severe health changes, relationship breakups, miscarriages, stillbirths, abortions, adoptive placements, moves, etc. Please note if your family does or does not know this information.

What concerns or problems have you been experiencing which brought you into counseling at this time?

Please check any problems you feel you might be having at this time.

- [ ] Difficulty falling asleep
- [ ] Difficulty staying asleep
- [ ] Sleeping too much
- [ ] Poor appetite
- [ ] Eating too much
- [ ] Binge eating or purging
- [ ] Drinking too much alcohol
- [ ] Over use of medications or other drugs
- [ ] Other compulsions (sexual, gambling, etc.)
- [ ] Suicidal thoughts
- [ ] Homicidal thoughts
- [ ] Problems with concentration
- [ ] Health Problems
- [ ] Change in moods
- [ ] Racing thoughts
- [ ] Relationship problems
- [ ] Seeing things or hearing things that are not there
- [ ] Severe financial problems
- [ ] Job Stress
- [ ] Gender Identify issues
- [ ] Elder Care issues
- [ ] Parenting issues
- [ ] Other

Primary Health Care Provider and other providers treating current conditions.

List all diagnosed physical and psychological health problems. Include any health concerns that need to be address but time, money or other barriers have led to it not being resolved.

List all medications, over the counter medications or holistic remedies that you use.

Please share any additional circumstances that are not covered in this form but will help me learn more about your life.

Are you at risk of going to jail or have you already experienced a jail or prison sentence. Please describe what has happened.

Which of the following may apply to your situation.

- ☐ Problems with primary support group − family discord, child and marital issues, conflict with parents, death in the family, sexual or physical abuse, child apprehended by child services
- ☐ Problems related to the social environment − socially isolated, no friends, living alone, no social supports, manipulated by peers, challenges with peer groups
- ☐ Educational problems − academic problems, stress from education program
- ☐ Occupational problems − unemployed, stress at work, workplace disputes
- ☐ Housing problems − homelessness, underhoused, no fixed address, stress due to housing situation
- ☐ Economic problems − financial difficulties, poverty, issues with disability support payments
- ☐ Problems with access to health care − health care provider not accessible, no health provider, no health insurance
- ☐ Other psychosocial and environmental problems − any issues related to immigration that were not social or occupational in nature, including refugee status & refugee claimant process.

Please Initial and Date