WESTSIDE CENTER
for COUNSELING and THERAPY
205 S. Minnesota Street
Carson City, NV 89703-4269

Therapist: _____

Adult History Form

In order for us to be able to fully evaluate you, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to; do the best you can. Thank you!

PATIENT IDENTIFICATION

Name:_____ First Appointment Date:_____
Birth Date:_____ Age _____ Sex_____
Religion _____ Marital Status_____
Race_____ Children_____
Address:_____
City_____ State _____ Zip_____
Home Phone # _____ Work #_____ Cell_____

REFERRAL SOURCE

Referral Source_____
Referral Address _____Phone #_____
Do we have your permission to release information to the referring professional when it is appropriate? Yes ____ No_____

PURPOSE OF THE CONSULTATION

(Please give a brief summary of the main problems)

_____
_____
_____
_____
_____
_____
_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME?

_____
_____
_____
_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS / PRIOR PSYCHIATRIC HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)
What do you want this clinician to do for you?

_____
_____
_____
_____
_____

MEDICAL HISTORY

Current medical problems/medications _____
_____
Past medical problems/medications _____
_____
Other doctors/clinics seen regularly_____
_____
Any history of head trauma? (describe) _____
_____
Ever any seizures or seizure like activity?_____
Any periods of spaciness or confusion?_____
Prior hospitalizations (place, cause, date, outcome) _____
_____
Prior abnormal lab tests, X-rays, EEG, etc. _____
_____
Allergies/drug intolerances (describe) _____

Present Height: _____ Present Weight:_____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)

_____
_____
_____
_____

FAMILY HISTORY

Family Structure (who do you currently live with, add other information as necessary)

_____
_____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)_____
_____
_____
_____

Current Marital or Relational Situation/Satisfaction

_____

_____

_____

History of Past Marriages _____

_____

Natural Mother's History: Age_____ Outside Work_____
School: Highest grade completed _____
Learning problems (specify) _____
Behavior problems (specify) _____
Marriages _____
Medical Problems _____
Childhood atmosphere (family position, abuse, illnesses, etc.) _____

_____

_____

Has mother ever sought psychiatric treatment? Yes _____ No _____
If yes, for what purpose? _____

_____

Mother's alcohol/drug use history _____

Have any of mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

_____

_____

Natural Father's History: Age_____ Outside Work_____
School: Highest grade completed _____
Learning problems (specify) _____
Behavior problems (specify) _____
Marriages _____
Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc.) _____

_____

_____

Has father ever sought psychiatric treatment? Yes _____ No _____
If yes, for what purpose? _____

_____

Father's alcohol/drug use history _____

Have any of father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

Siblings (names, ages, problems, strengths, relationship to patient)

Children (names, ages, problems, strengths)

EDUCATIONAL HISTORY

Last grade completed _____
Last school attended _____
Average grades received _____
Any academic problems? _____
Learning strengths _____
Any behavior problems in school? _____
What would your teachers have said about you? _____

EMPLOYMENT HISTORY: (summarize jobs you've had, list most favorite and least favorite)

Any work-related problems? _____
What would your employers or supervisors have said about you? _____

MILITARY HISTORY: _____

EVER ANY LEGAL PROBLEMS? _____

ALCOHOL AND DRUG HISTORY: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.) These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.) cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

Ever experience withdrawal symptoms from alcohol or drugs? _____
Has anyone told you they thought you had a problem with drugs or alcohol? _____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____

Have you ever used drugs or alcohol first thing in the morning? _____
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____

Cultural/Ethnic Background _____

Describe your relationships with friends _____

Describe yourself _____

What are your goals in seeking this consultation? What do you hope to gain? _____