Client ID #_____

Midwest Behavioral Care, Ltd.

Administrative Office

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ADULT HISTORY FORM

Client Name: _____ Date of Birth_____ Age: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone:_____
Insurance ID#: _____ Date _____

Purpose of this form: The purpose of this questionnaire is to obtain a comprehensive picture of your background along with current strengths and difficulties. Completing these questions as fully and accurately as possible will be of help to you and to your therapist in providing services to you.

This information is considered confidential and will be treated as outlined in the **Client Information and Policy Statement.**

If you do not want to answer any of the items, write: "Do not want to answer."

Referral Data
How did you find out about our practice? _____
_____
By whom were you referred? _____
May we inform him/her that you have initiated psychotherapy? _____

List of Current Symptoms: (Please check all that apply. Those not checked will be assumed absent.)

__ Depressed Mood
__ Decreased Energy
__ Grief
__ Hopelessness
__ Feelings of Worthlessness
__ Guilt
__ Nervousness/Anxiety
__ Panic Attacks
__ Obsessions/Compulsions
__ Elevated Mood
__ Irritability
__ Hyperactivity
__ Disruption of Thought Process/Content
__ Delusions
__ Hallucinations
__ Paranoia
__ Dissociative States
__ Oppositional
__ Somatic Complaints
__ Medical Illness
__ Impulsivity
__ Emotional/Physical/Sexual Trauma Victim
__ Emotional/Physical/Sexual Trauma Perpetrator
__ Substance Use (check one)
___ Active Substance Abuse
___ Early Full Remission
___ Early Partial Remission
___ Sustained Partial Remission
___ Other (specify):_____
__ Other (specify):_____

Symptoms have been present for:
___ Less than 1 month ___ 1 to 6 month ___ 7 to 12 months ___ 1 to 3 years ___More than 3 years

Current Impairment:

Categories	No Impairment	Mild Impairment	Moderate Impairment	Marked Impairment	Extreme Impairment
	Impairment Level (circle level)				
Marriage/Relationship/Family	1	2	3	4	5
Job/School/Performance	1	2	3	4	5
Friendship/Peer Relationships	1	2	3	4	5
Financial Situation	1	2	3	4	5
Hobbies/Interests/Play Activities	1	2	3	4	5
Physical Health	1	2	3	4	5
Legal Status (Arrest, Probation)	1	2	3	4	5
Activities of Daily Living (personal hygiene, bathing, etc.)	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleeping Habits	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control His/Her Temper	1	2	3	4	5

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Risk Assessment: **(underline all that apply)**

Suicidality	Not Present	Ideation	Plan	Means	Prior Attempt
Homicidality	Not Present	Ideation	Plan	Means	Prior Attempt

Problem Description

In your own words, what are the difficulties you are currently experiencing?
_____
_____
_____
_____
When did these difficulties first begin? _____
Was there some specific incident or event which seemed to cause these difficulties to begin?
_____ If so, what? _____
_____
What have you done on your own to attempt to resolve these concerns? _____
_____
_____
_____
How have these solutions worked? _____
_____
Have you contacted other professionals for help with these concerns? _____
If so, whom? _____
When? _____ For how long?_____
What aspects of this were most helpful? _____
Least? _____

Family History

By whom were you raised?(If several sets of circumstances, list all, and your ages for each.)_____
_____
Where did you grow up?_____ Was this urban, rural, small town, etc.?_____
Parents' education (highest grade completed). Mother_____ Father_____
Parents' occupation (Pre-retirement). Mother_____ Father_____
Parents' religious affiliation. _____ Yours_____
Please list all brothers and sisters including first names and their ages, from oldest to youngest, and including yourself in the appropriate position._____
_____
_____
Check below if any of the following have happened to you? If yes, indicate the age(s) at which they took place on the lines to the left of the event:

___ Death of Mother_____ ___ Desertion by Mother_____
___ Death of Father_____ ___ Desertion by Father_____
___ Death of Sibling (Sex?)_____ ___ Parent(s) alcoholic/addicts_____
___ Separation of Parents_____ ___ Long-term illness in family_____
___ Parental Divorce_____ ___ Mental illness in family_____
___ Physical Abuse (by whom?)_____ ___ Sexual Abuse (by whom?)_____
___ Serious illness (self)_____ ___ Adopted_____

Use this space if you want to explain more about any of these:
_____
_____
Describe your mother's personality and her attitude toward you, past and present.
_____
_____
_____
_____
Describe your father's personality and his attitude toward you, past and present.
_____
_____
_____

Describe what your home life was like as you were growing up.

_____

_____

Current Family/Significant Others

Marital status (please circle all applicable): Single Engaged
Married Separated Divorced Widowed Co-habitating
List those living with you, their ages, and relationship to you:

_____

_____

_____

How many times have you been married? _____
Give dates of your marriages: _____
How did these marriages end, and when? _____
Do you have children not living with you? _____ If so, list them, why they live elsewhere, and the quality of your relationship with them now:_____

_____

Briefly describe the positive qualities of your current marital/romantic relationship:

_____

_____

_____

Briefly describe the negative aspects of the relationship:

_____

_____

_____

_____

If the quality of your sexual relationship(s) is an issue you wish to address in therapy, Please indicate here, and a more thorough history will be taken later:

_____

_____

If the quality of your relationships with children, or parenting issues, are something you wish to address in therapy, please indicate here:_____

_____

How many different people have you dated since the onset of adolescence? _____

Do you think you dated enough before making a commitment to a relationship? _____
Are there other important aspects of your current significant relationships that you would like to add? _____

_____

_____

_____

Social Relationships

How often do you socialize with others?_____
How many friends do you have who you see socially at least once per month?_____
What sorts of activities do you participate in with them?_____

_____

Do you have close friends with whom you can discuss your problems, interests, and concerns? _____ How many?_____
What hobbies or leisure activities do you pursue?_____

_____

What clubs or organizations do you participate in?_____

_____

Medical/Physical Functioning

What is your height?_____ Weight?_____
When was your last physical examination? _____Were there any abnormal or irregular findings?_____

_____

Who is your family physician?_____
Address:_____
City, State, Zip:_____ Phone_____

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Check any of the following you have had:

___ Breathing Problems ___ Dizziness/Fainting ___ Stroke
___ High Blood Pressure ___ Heart Condition ___ Diabetes
___ Neurological Problems ___ Endocrine Problems ___ Cancer
___ Pregnancy/Abortion ___ Epilepsy/Convulsion ___ Headaches
___ Other (list) _____

List any surgeries you've had, and dates_____

List any current medical problems_____

List any medication you are currently taking:

Medication	Dosage	#, times/day	Why prescribed?

Note any adverse effects or side effects that you have to any medications:_____

Check those you are currently experiencing:

___ Sleep problems (circle all that apply) too much too little early awakening frequent awakening sleepwalking hard to get to sleep

___ Eating problems (circle all that apply) too much too little eating when not hungry

List any allergies you have: _____

Mental Health History

Have you ever been treated by a mental health professional or by your physician for emotional or mental health issues?_____ (If "no", skip this section.)

Name of professional and/or facility, and dates of treatment:

_____ _____
_____ _____
_____ _____

(Please check here if we may request your treatment records from them._____)

What were the issues that brought you to those professionals?_____

How were the issues resolved?_____

What aspects of treatment were most helpful? _____

Least? _____

If you have been on medications for mental health reasons (other than those listed in the medical section above) at any time in the past, please list here:

Medication	Dosage	#, x/day	Why prescribed?	When Used?

Who are the most important people in your life? _____

Describe any fearful or distressing experiences not previously mentioned _____

Have you ever lost control (e.g. temper, crying, aggression? If so please explain.

_____
_____
_____

Substance Use and Dependency

How often do you currently use the following substances? (Place a check in the column to Indicate current use; *if your past use was different, indicate this by writing "past" in the appropriate column next to each substance*.)

	Daily	3-5x/week	1-2x/week	2-3/month	1/month	seldom	never
Beer	___	___	___	___	___	___	___
Wine	___	___	___	___	___	___	___
Distilled Alc.	___	___	___	___	___	___	___
Marijuana	___	___	___	___	___	___	___
Cocaine	___	___	___	___	___	___	___
Crack	___	___	___	___	___	___	___
Barbiturates	___	___	___	___	___	___	___
Amphetamines	___	___	___	___	___	___	___
Tranquilizers	___	___	___	___	___	___	___
Analgesics	___	___	___	___	___	___	___
Heroin	___	___	___	___	___	___	___
Tobacco	___	___	___	___	___	___	___
Caffeine	___	___	___	___	___	___	___
Other (List)	___	___	___	___	___	___	___
Other (List)	___	___	___	___	___	___	___

Have you ever had job, relationship, financial, legal, social, or physical problems as a result of your substance use?_____ Describe._____
_____
_____
Has anyone in your family ever had problems with substance abuse or dependency? _____
Who, and what substances?_____
_____
Have you or others in your family been involved in treatment for substance use or dependency? Describe._____
_____
Have you ever been involved with a 12-step group (AA, Al-Anon, etc.)?_____
Are you now? _____ What group(s)?_____

Behavioral Addictions:

Do you consider yourself to be addicted to activities or behaviors which are not chemical in nature (e.g., food, television, exercise, gambling, sex, etc.)?_____
If so, what? _____
Any prior treatment for these?_____
Twelve-step involvement/what program? _____

Educational/Occupational Functioning:

Current Occupation/vocation_____
Length of time in current vocation_____
Do you consider your vocation fulfilling for you?_____
Are you considering changing jobs or vocations?_____
Have you had any disciplinary actions against you at work?_____
If you could have any job you wanted, what kind of job would you choose?_____
List your highest educational achievement (HS diploma, B.A., 2 years college, etc.)_____
Your grades were: Above average_____ Average_____ Below Average_____
Extracurricular activities you participated in:_____
_____
If you left high school before graduation, note the reason:_____
Did you get a GED?_____
What was your family's income last year?_____ How many people did this income support?
_____

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MILITARY HISTORY:

If you are a veteran, what did you do in the service?_____
What was your highest rank?_____ Tell us about any demotions, court martials, etc._____
Where were you stationed and when?_____
Where you ever hospitalized in the service?_____

For how long?_____
Do you receive compensation for a service disability?_____
What kind of discharge did you receive?_____

Legal History:

Have you ever been convicted of a felony? (Give Details)_____

_____
Are you currently on probation or parole? (Give Details)_____
_____

Have you been ordered to receive counseling as a result of your involvement with the legal system? (Explain)_____
Please list any other individuals or legal agencies with whom you will need for us to confer (to meet conditions of parole, etc.)_____

If you wish for us to be in contact with your attorney, please list data here:
Attorney's Name and Address: _____
City, State, Zip: _____ Phone_____

Please list here anything that has not been asked that you believe is important historical or situational information:_____
_____
_____
_____
_____
_____

List the benefits you hope to derive from counseling/therapy. This is very important. Please be specific:
1) _____
2) _____
3) _____

Do you think you would be helped more by:
A. Directions to change specific behaviors
B. Talking about your problems individually
C. Psychological testing
D. Receiving medicine
E. Group therapy
F. Family therapy

_____
_____
_____

ADDITIONAL INFORMATION: Please list all psychologists, physicians, speech therapists, clinic, etc. which you have had contact with. Also please tell us any other significant information about you that we may not have asked about. Write on the back of the sheet if you wish.