Charles D. Mills, Ph.D.

ADULT HISTORY FORM

Please fill in this form as completely as possible. It will provide the therapist background history to better serve your needs.
Insignificant information may prove valuable to your therapy.

Date _____

Client name (first, middle initial, last) _____
Street Address: _____ City: _____ Zip: _____
Home phone _____ **m**ay **l**eave **m**essage (please circle Yes/No)
Cell phone _____ Work phone _____
Birth Date _____ Age _____ Gender: Female ____ Male ____ Social Security # _____
Employer _____ Occupation _____ Full time/part time

Referral source: _____

Reason for seeking counseling:

_____

_____

Emergency contact _____ Phone _____
Relationship to client _____

Primary Care Physician _____Phone _____Fax _____
Primary Care Physician Address _____ City: _____Zip: _____

Primary Insurance _____ Phone _____
Subscriber name _____ DOB:_____ Social Security # _____
Subscriber relationship to client _____ Subscriber employer _____
Contract # _____ Group # _____

Secondary Insurance _____ Phone _____
Subscriber name _____ DOB: _____ Social Security # _____
Subscriber relationship to client _____ Subscriber employer _____
Contract # _____ Group # _____

Family Information

Mother's name _____ Age _____ Living with you? □Yes □No
Father's name _____ Age _____ Living with you? □Yes □No
Spouse's name _____ Age _____ Living with you? □Yes □No
Children's name(s) _____ Age _____ Living with you? □Yes □No
_____ Age _____ Living with you? □Yes □No
_____ Age _____ Living with you? □Yes □No
_____ Age _____ Living with you? □Yes □No
_____ Age _____ Living with you? □Yes □No
_____ Age _____ Living with you? □Yes □No

Brothers and Sisters:

Name _____ Age _____ Name_____ Age _____
Name _____ Age _____ Name _____ Age _____
Name _____ Age _____ Name _____ Age _____
Name _____ Age _____ Name _____ Age _____
Name _____ Age _____ Name _____ Age _____

Marital Status:

- □ Single
- □ Unmarried & living with significant other
  Length of time _____
- □ Legally Married
  Length of time _____
- □ Separated
  Length of time _____
- □ Total # of marriages _____
- □ Divorce in progress
- □ Divorced
  Length of time _____
- □ Widowed
  Length of time _____
- □ Annulment
  Length of time _____

Parent Information:

- □ Parents legally married
- □ Parents ever separated
- □ Parents ever divorced
- □ Mother remarried: # of times _____
- □ Father remarried: # of times _____

Special circumstances (e.g. raised by person other than parents, information about spouse/children not living with you, etc.)

_____
_____
_____

DEVELOPMENT

Circumstances that affected your development: (child abuse, sexual abuse, inadequate nutrition, neglect, etc.)

_____
_____

SOCIAL

Describe how you relate to people (e.g., easily, shy, leader, follower, extrovert, introvert, etc.):

_____
_____

Who do you socialize with?

_____
_____

Do you isolate yourself from other people? Yes□ No□ Explain:

_____
_____

CULTURAL/ETHNIC INFORMATION

What cultural or ethnic group do you come from? _____

Do you closely identify with this group, and if so, do you see this as a strength or weakness? _____

SPIRITUAL/RELIGIOUS

Do you consider yourself a spiritual person? Yes☐ No☐

In what religion were your raised?

_____

Do you practice a form of religion now? Yes☐ No☐ If so, what religion do you currently practice?

_____

LEGAL

Current status:

Are you involved in any active cases (traffic, civil, criminal): Yes☐ No☐

If yes, please describe:

_____

_____

_____

Are you presently on probation or parole: Yes☐ No☐ NA ☐

If yes, please describe:

_____

_____

_____

_____

Past History:

Yes☐ No☐ Traffic violations

Yes☐ No☐ DUIL etc.

Yes☐ No☐ Civil involvement

Yes☐ No☐ Criminal involvement

If yes to any of the above, please complete the following:

Charges	Date	Where	Results

EDUCATION

Check all that apply:

☐ High school diploma/GED ☐ Currently enrolled: last grade completed_____

☐ Did not complete high school: last grade completed _____

☐ College: ☐ Currently enrolled ☐ Number of years completed_____ ☐ Degree earned _____

☐ Vocational training ☐ Currently enrolled ☐ Training completed Specialty _____

Special circumstances (e.g. learning disabilities, gifted program, special education, etc.):

_____

_____

EMPLOYMENT/VOCATIONAL

Beginning with the most recent job, give employment history: (include homemaker experience)

Employer	Dates	Job Description	Salary

Total yearly income: $ _____

Special circumstances (laid-off, self-employed, suspended, disabled, retired, social security, etc.)

_____

MILITARY

Combat experience? Yes☐ No☐ When _____ Where _____

Branch _____ Discharge date_____
Date drafted _____ Type of discharge_____
Date enlisted _____ Rank at discharge_____

LEISURE/RECREATIONAL

Describe any interests or hobbies:

Art _____ Books/Films _____
Music _____ Physical fitness _____
Crafts _____ Diet/Health _____
Outdoor activity _____ Sports _____
Church activity _____ Other _____

Has your activity level changed recently? Yes☐ No☐ If yes, please describe

_____

_____

PHYSICAL HEALTH

PHYSICAL HEALTH	Date	Reason	Results
Last physical			
Last doctor's visit			
Last dental visit			

Your current physician: _____ Phone: _____
Street Address _____ City: _____ Zip: _____

Check all that apply and describe below:

- ☐ Aids
- ☐ Alcoholism
- ☐ Abdominal pain
- ☐ Allergies
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Bed wetting
- ☐ Cancer
- ☐ Chest pain
- ☐ Chronic pain
- ☐ Colds/coughs
- ☐ Constipation
- ☐ Chicken Pox
- ☐ Dental Problems
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ Ear Infections
- ☐ Eating Problems
- ☐ Fainting
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Menstrual Pain
- ☐ Neurological Disorders
- ☐ Nausea
- ☐ Nose Bleeds
- ☐ Pneumonia
- ☐ Rheumatoid Fever
- ☐ Sleeping Disorders
- ☐ Sore Throat
- ☐ Scarlet Fever
- ☐ Sinusitis
- ☐ Small Pox
- ☐ Stroke
- ☐ Sexual Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Toothache
- ☐ Thyroid Problems
- ☐ Vision Problems
- ☐ Veneral Disease
- ☐ Vomiting
- ☐ Whooping Cough
- ☐ Other _____

Explain:
_____
_____

Current Medications:
_____
_____

Over the counter medications:
_____

Medication/Drug Allergies (describe affect):
_____

List any surgeries and dates:

_____

_____

Any recent changes in:

Sleep patterns	Yes☐	No☐	Physical activity level	Yes☐	No☐
Eating pattern	Yes☐	No☐	General Disposition	Yes☐	No☐
Behavior	Yes☐	No☐	Weight	Yes☐	No☐
Energy level	Yes☐	No☐	Increase in nervousness or tension	Yes☐	No☐

If you answered yes to any of the above, please explain:

_____

_____

_____

CHEMICAL USE HISTORY

	Method of use and amount	Age of first use	Age of regular use	Used in last 48 hours?		Used in last 30 days?	
				Yes	No	Yes	No
Alcohol							
Barbiturates							
Valium/Librium							
Cocaine/Crack							
Heroin/Opiates							
Marijuana							
PCP/LSD/Mescaline							
Inhalants							
Caffeine							
Nicotine							
Over The Counter							
Prescription Drugs							
Other Drugs							

Substance of preference:

1. _____
2. _____
3. _____
4. _____

Substance Abuse Questions:

Describe when and where you typically use:

_____

_____

Describe any changes in your use patterns:

_____

_____

Describe how your use has effected your family or friends:

_____

_____

Do you use to build up your confidence: Yes☐ No☐

What is your perception of your use?

_____

_____

Describe who or what:

_____

_____

Who in your family (past/present) has had a problem with drugs or alcohol:

_____

_____

Have you had withdrawal symptoms when trying to stop drinking:

_____

_____

Does your temperament change when you drink (describe):

_____

_____

Has alcohol/drugs created a problem for your job:

_____

_____

COUNSELING/PRIOR TREATMENT INFORMATION

Information about client (past and present):

	Yes	No	When	Where	Briefly describe
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Involvement with self-helps groups (e.g. AA, Al-Anon, Overeaters Anonymous, etc.)					

Information about family/significant others (past and present):

	Yes	No	When	Where	Briefly describe
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Involvement with self-helps groups (e.g. AA, Al-Anon, Overeaters Anonymous, etc.)					

Any additional information that would assist us in understanding your concerns or problems:

_____
_____
_____

When and how did these problems start:

_____
_____
_____

What are your goals for therapy?

_____
_____
_____

Do you feel suicidal at this time? Yes☐ No☐

_____ _____
Form Completed By (Signature) Date

_____ _____
Charles D. Mills, Ph.D. Date
Licensed Psychologist

Physical Exam: ☐Required ☐Not required

_____
_____
_____
_____
_____
_____
_____