

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 _____ may leave message (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 you 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 DUI 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
- Tonsillitis
- Tuberculosis
- Toothache
- Thyroid Problems
- Vision Problems
- Venereal 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 <input type="checkbox"/>	No <input type="checkbox"/>	Physical activity level	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eating pattern	Yes <input type="checkbox"/>	No <input type="checkbox"/>	General Disposition	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Behavior	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Weight	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Energy level	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Increase in nervousness or tension	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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.
Licensed Psychologist

Date

Physical Exam: Required Not required
