# 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 names | _____ | Age _____ | Living with you? □Yes □No |
| | _____ | Age _____ | Living with you? □Yes □No |
| | _____ | Age _____ | Living with you? □Yes □No |

Children's names _____ 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 | | | |

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 _____

Please explain any of the above:

_____

_____

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. _____ 3. _____

2. _____ 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

_____
_____
_____
_____
_____
_____
_____