Adult Information Form

Name:	**Date:**	
Date of Birth:	Age:	
Driver's License #:	SS#:	
Home Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email:		
Preferred Method of Contact:	¨ Home Phone	¨Cell Phone
Ethnicity (check all that apply):	¨ African American ¨ Hawaiian/Pacific Islander ¨ Asian ¨Other:	¨Caucasian ¨American/Alaskan Indian ¨ Latino/a
Religion:	¨ Catholic ¨ Protestant ¨ Jewish ¨Buddhist ¨ Hindu ¨Christian ¨ Islamic ¨ Jewish	¨Buddhist ¨Hindu ¨Other:
Sexual Orientation:	¨ Heterosexual ¨ Bisexual ¨ Other:	¨Lesbian/Gay ¨Uncertain ¨Decline to state
Relationship Status:	¨ Single, not dating ¨ Committed Relationship ¨ Married ¨ Other:	¨ Single, dating ¨ Widowed ¨ Divorced
Parent Status:	¨ No Children ¨ Biological Parent ¨ Step-parent/Co-parent	¨Adoptive Parent ¨Foster Parent ¨ Other:
Child's Name:		Age:
Child's Name		Age:
Child's Name		Age:

Insurance Information:	
Name of Primary Insurance:	
Name of Secondary Insurance, if applicable:	
Secondary Insurance Policy #:	
Person to be Billed for Fees	
Name:	Relationship to you:
Address (Check box if same as above): ¨	

City:	State:

Emergency Contact:	
Name:	
Address:	
City:	State:
Home Phone:	Cell Phone:

Employer Name:	**Job title:**
Spouse/Partner Employer Name:	
Active Duty Military: ¨ Yes ¨No Branch:	Rank:
Deployments or Duty Stations Overseas ¨ Yes ¨ No	

Highest Level of Education Completed:

¨ Some High School ¨ High School Diploma/GED ¨ Some College
¨ Technical/Apprentice Cert. ¨ AA Degree ¨ BA/BS Degree
¨ MA/MS Degree ¨ MD/JD/Doctoral Degree

Please fill in the chart below regarding your current living situation:

Name	Age	Relationship	Occupation

Health History	
Primary Care Physician's Name:	
Date of last appointment:	Phone #:
Address:	
Please list any serious illness or recent surgeries:	
Please list any serious illness, surgeries, and medical problems that you have ever had:	

Please list any current medications:

Medication Name	Dosage	Reason

Psychological History	
Have you ever seen a therapist? ¨Yes ¨ No	Have you ever seen a psychiatrist? ¨Yes ¨ No
Therapist's Name:	Phone:
Address:	City:
Psychiatrist's Name:	Phone:
Address:	City:
Dates of treatment:	
Please describe what was helpful or not:	

Legal History
As a child or teenager, were you ever arrested? ¨ Yes ¨ No If yes, for what reason?
As an adult, have you ever been arrested? ¨ Yes ¨ No If yes, for what reason?

Drug and Alcohol History
As a child or teenage, did you ever drink alcohol? ¨ Yes ¨ No Age first used:
Did you ever use drugs? ¨ Yes ¨ No Age first used:
As an adult, did you ever drink alcohol? ¨ Yes ¨ No
Did you ever use drugs? ¨ Yes ¨ No
If yes, which drug have you taken? (check all that apply) ¨ Marijuana ¨ Speed ¨ Inhalants ¨ Hashish ¨ Steroids ¨ K ¨ Cocaine ¨ Mushrooms ¨ X ¨ Crack ¨ Acid ¨ Meth/Crystal ¨ Heroin ¨ Spice ¨ Barbiturates/Tranquilizers
Do you currently drink alcohol? ¨ Yes ¨ No
Do you currently use drugs ¨ Yes ¨ No
If yes, which drug have you currently use? (check all that apply) ¨ Marijuana ¨ Speed ¨ Inhalants ¨ Hashish ¨ Steroids ¨ K ¨ Cocaine ¨ Mushrooms ¨ X ¨ Crack ¨ Acid ¨ Meth/Crystal

¨ Heroin	¨ Spice	¨ Barbiturates/Tranquilizers

Briefly explain why you are seeking therapy at this time:
List any major changes or life events that have occurred in the last two years:
What are your major strengths?

What is your of involvement with the following (how much/how often?):

Alcohol:	
Cigarettes/tobacco:	
Coffee/caffeine:	
Other addictive substances:	
Gambling:	
Television/Internet:	
Exercise:	
How do you relax and how often?	
How much do you sleep?	

Thank you for your time, and I look forward to meeting you soon!