ADULT BACKGROUND INFORMATION

Your decision to seek counseling means you want to improve your life. Our goal is to work with you to solve problems and gain a new perspective about yourself and how you relate with other people.

The more you share with your therapist about yourself and your life experiences, the better able he/she will be to help you. The following questions are designed to gather important information that can be utilized in the therapy sessions.

We know that this form seems long and none of us enjoy paperwork. It will take you approximately one hour to complete it. We understand that some of the questions may be difficult to answer briefly, and others may not apply. Feel free to write on the back of the form or add extra paper if necessary.

Your responses to the questions, like all aspects of psychotherapy, will be held confidential to the limitations of confidentiality as defined by the laws of Tennessee. The time you spend completing this form will allow you and your therapist to use the therapy sessions to focus directly on exploring in more depth the specific issues relating to your presenting problems

Thank you for your cooperation.

Leave blank any questions you are uncomfortable answering.

NAME: _____

SEX: _____ BIRTHDATE: _____

TODAY'S DATE: _____

Client Name_____

What leads you to seek therapy at this time?

How long have these problems been troubling you?

What would you like to accomplish in therapy?

Have you been involved in counseling in the past? ____Yes ____No

- What type of therapy? ___Individual, ___Marital, ___Family
- Name(s) of previous therapist? _____
- Was therapy helpful? ___Yes ____No
- Have you ever felt suicidal? ___Yes ___No
- Have you ever attempted suicide? ___Yes ___No When:_____

Mental Illness

Is there a history of mental health problems in your family? (Circle to indicate F=father; M=mother; S=sibling; O=other family member) None_____

Depression: F / M / S / O: _____ Anxiety: F / M / S / O: _____
Bi-Polar Disorder: F / M / S / O: _____ ADHD: F / M / S / O: _____
Alcoholism: F / M / S / O: _____ Drug Addiction: F / M / S / O: _____
Other Addictions: F / M / S / O: _____ Suicide: F / M / S / O: _____
Other Problems: F / M / S / O: _____

Alcohol Use

How many drinks do you have in a typical day?

None___ 1-2___ 3-4___ 4or more___

What ñrecreational drugsò do you use/ have you used? None___

Marijuana___ Cocaine or Crack___ Hallucinogenics___ Opiods or Pain Killers___
Methamphetamine___ Benzodiazepines or anti-anxiety___ Ecstasy___

Other_____

Are people in your life concerned about your drinking or drug usage? Yes___ No___

Have you experienced any problems due to drinking or the use of other mood-altering substances? Yes___ No___ If so, please explain:

Client Name_____

MEDICAL INFORMATION:
Are you being treated for any specific medical condition? If **yes,** please describe and give your primary care physicianôs name.

List any major illnesses, surgeries, or injuries, including head trauma.

List any allergies, including allergies to medication.

Are you menopausal or pre-menopausal? Yes___ No___

How would you describe you current physical health?

How many hours of sleep do you average per night? _____\

Do you use tobacco products? Yes___ No___
Cigarettes: ___ packs per day___ other products_____

List all medications you are currently taking (both prescribed and ñover-the-counterò), including dosage, frequency, and prescribing physician.

Drug	Dosage	Frequency	Prescribing Doctor

MARRIAGE AND FAMILY INFORMATION:

Are you married? Yes___ No___

If yes, how long have you been married? _____

How would you describe your present marriage relationship?

Have you been divorced? Yes___ No___ Widowed? Yes___ No___

How many times have you been married? _____

Do you have children? Yes___ No___

What are the names, ages and sex of your children?

Name: Age: Gender (M/F):

Do your children live with you? Yes___ No___

Is yours a blended family? Yes___ No___

Describe your relationship with your children/step-children.

Is there a history of domestic abuse in this relationship or any previous relationship? Yes___ No___ If yes, please describe the situation (s):

EDUCATION:

- Graduated High School Yes___ No___
- Graduated College Yes___ No___
- Completed Graduate School Yes___ No___

Do you have a history of learning disabilities? Yes___ No___ If **yes, what** type?

How would you describe your academic experience?

FAMILY BACKGROUND INFORMATION

Where did you grow up?

List the people who lived with you as you grew up (e.g. parent(s), brothers and sisters, grandparents, live-in help, etc.)

NAME: RELATIONSHIP TO YOU:

Describe any significant problems you have had with any of the people listed above.

NAME: NATURE OF THE PROBLEM:

What words would you use to describe your father?

What words would you use to describe your mother?

How would you describe your home life while growing up (positive and/or negative qualities)?

Describe any childhood events you consider to be important in becoming the person you are now.

Did you experienced any physical, emotional, or sexual abuse in childhood? If **yes**, describe:

How were you treated by people outside your family?

Did you make friends easily with your peer group? Yes___ No___

How important are friends to you currently? Do you feel that you have any problems (1) relating with others ;(2) forming friendships; or (3) keeping friends?

What is your current occupation? How satisfied are you with your job?

Have you ever changed careers, been fired, or lost a job? Yes___ No___ Have you ever experienced significant job stress or job-related problems? If **yes** please describe.

What are your leisure interests?

What do you consider to be your strengths and limitations?

Have you ever had any legal problems? If so, describe.

Are you presently attending a church? Yes___ No___ If so, what church? _____

What role does your faith play in your day to day life?

Is there any other information about yourself that is not asked in this questionnaire which you would like your therapist to know about you?