

icChoice.com

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ADULT INFORMATION FORM

Name Date of 1st Appointment Therapist

Date of Birth Age Gender: Male Female

MEDICAL HISTORY

Name of Primary Care Physician:

Physician's Address: Physician's Phone:

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:

Date of last medical evaluation: Date of next appointment:

Current medications being taken:

- 1) Dosage/Freq Start Date Purpose
2) Dosage/Freq Start Date Purpose
3) Dosage/Freq Start Date Purpose
4) Dosage/Freq Start Date Purpose

Prescribed by:

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Table with 3 columns: Hospital Mo/Yr, Reason

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop?

Table with 3 columns: Type of Drug, How much, How often

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Table with 3 columns: Type of Alcohol, How much, How often

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind?

Describe any important medical history, chronic ailments, or other health problems you experience:

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|--|
| |
| |

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain: _____

What was the last year of school you completed? _____ If you did not complete high school, please explain: _____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s) _____ Year(s) _____

(2) School(s) _____ Year(s) _____

(3) School(s) _____ Year(s) _____

How would you describe your current support network? (friends, relatives, etc.): _____

Please check all information which applies to your biological parents:

| | | | | | |
|--------|--|--|--------|--|--|
| MOTHER | <input type="checkbox"/> living | | FATHER | <input type="checkbox"/> living | |
| | <input type="checkbox"/> deceased | | | <input type="checkbox"/> deceased | |
| | <input type="checkbox"/> married | | | <input type="checkbox"/> married | |
| | <input type="checkbox"/> divorced | | | <input type="checkbox"/> divorced | |
| | <input type="checkbox"/> remarried _____# of times | | | <input type="checkbox"/> remarried _____# of times | |

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

Where do your parents live? Mother _____

Father _____

Describe your relationship with your mother while growing up: _____

Currently: _____

Describe your relationship with your father while growing up: _____

Currently: _____

List first names and ages of brothers & sisters, including yourself:

| Name | Age | Relationship (natural, step, half, etc.) |
|-------|-------|--|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Describe any family problems which occurred while growing up relating to:
 Alcohol/drug abuse: _____

Sexual/physical/emotional
 abuse: _____

MARITAL HISTORY

Marital status: Single/never married Married Separated Divorced Widowed Living w/someone
 If currently married, when were you married? _____ If living w/someone, how long? _____
 Please list your children:

| Name | Age | Relationship (biological/step) | Lives with |
|-------|-------|--------------------------------|------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

sad anxious depressed frightened guilty angry ashamed aggressive resentful
 worthless tearful irritable confused extreme ups/downs jealous hopeless helpless

Describe any other feelings you have

had: _____

What activities or hobbies do you participate in? _____

Do you participate in regular exercise? (Circle One) YES NO Describe: _____

Describe your current working environment: _____

Have you had any change in sleeping habits? (Circle One) YES NO Describe: _____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with

dates: _____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with

dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with

dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please

explain: _____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please

explain: _____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): _____

THOUGHTS: Please check any of the following that apply to you:

_____ I sometimes hear voices even though no one nearby is talking to me.

_____ I sometimes feel that forces outside of me control me.

_____ I sometimes feel that other people control my thoughts.

_____ I sometimes have the same thought over and over and cannot control it.

_____ I sometimes feel that someone is out to hurt me or do something against me.

_____ I am sometimes unable to control my behavior. Please explain: _____

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|--|
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| |

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

THANK YOU!