

**Child & Family Guidance Center of Texoma
CLIENT HISTORY FORM---ADULT**

This form will assist your therapist in knowing about you and will be kept confidential.

Date: _____

Name: _____ Social Security #: _____

Birth Date: _____ Age: _____ Single ___ Married ___ Divorced

PRESENTING PROBLEM:

Describe the problems you are having and note when they began:

What has contributed to this difficulty?

PERSONAL HISTORY:

Education:

What is the highest grade you have completed? _____

Did you have any problems in school? If so, please name them _____

Occupation:

What is your occupation? _____

Where are you employed? _____

How long have you worked for this employer? _____

Military History:

Have you served in the military? _____ If so, what branch? _____

Number of years you served _____ Type of discharge from service _____

Legal:

Have you EVER been involved with the legal system? (criminal, divorce custody, civil, etc.) If so, in what way? _____

Are you CURRENTLY involved with the legal system? (criminal, divorce, custody, civil, etc.) If so, in what way? _____

Do you personally have any criminal or civil cases pending? _____

Do you currently have a probation/parole officer? _____ If so, who? _____

Do you anticipate any future involvement with the legal system? _____

MEDICAL:

List allergies, serious illnesses, injuries, hospitalizations.

List current prescription and over-the-counter medications that you use for physical illnesses: _____

Over-all general health is: ___ Excellent; ___ Good; ___ Fair; ___ Poor

CFGC Adult Information con't.

What physical illnesses run in your family?

Who is your personal doctor? _____

TREATMENT HISTORY:

Have you ever had counseling? _____ If so, with whom? _____

When? _____ For how long? _____

What was your primary concern? _____

How helpful was the counseling/therapy? _____

Have you ever been hospitalized for emotional problems or for alcohol/drug treatment? _____ If so, when? _____

Where? _____

What was the outcome of your treatment? _____

What past medications have you taken for emotional/mental problems?

What medications are you currently taking for emotional/mental problems?

Is there a history of mental illness in your family? _____ If so, please describe:

SOCIAL HISTORY:

What are your most positive qualities/strengths?

What qualities/actions would you like to change about yourself?

Who gives emotional support to you?

List the losses, changes, crises, and transitions in your life:

What belief system (cultural, moral, spiritual, religious, etc.) influences your life?

Please list anything about your lifestyle (or the family's) that you believe would be helpful for your therapist to know.

CFGF Adult Information con't.

FAMILY HISTORY ABOUT THE FAMILY IN WHICH YOU GREW UP:

Name Age Relationship to You How do you get along?

Did you live away from your parents during childhood? If so, what was the reason?

Experiences while a person is growing up can have a strong affect on her/his life. Please list the experiences/events (discipline, favoritism, trauma, affection, lack of attention, etc.) that have been important in your life.

PEOPLE WHO ARE LIVING IN YOUR HOME

Name Age Relationship to You How do you get along?

SPOUSES/PARTNERS

Name Time Together Reason for Ending Relationship

CHILDREN NOT LIVING WITH YOU: Is child a biological or step-child?

Name Age/Relationship Live Where/How do you get along?

CONCERNS:

Have you or any of the above relationships (people in your household, brothers/sisters, spouses/partners) ever experienced any of the following:

Concern: Person who experienced the concern:

Mental Illness _____

Depression _____

Neglect _____

Sexual Dysfunction _____

Financial Difficulty _____

Physical Abuse _____

Sexual Abuse _____

Emotional Abuse _____

Alcohol Abuse _____

Drug Abuse (Prescription and/or Illegal) _____

Other _____

During your childhood, did you experience any sexual behaviors or comments which made you uncomfortable? _____

SUBSTANCE ABUSE:

Do you use drugs? (Regularly? Occasionally? How does usage affect your life?)
Please circle the drugs you have taken.

- ___ DEPRESSANTS: Alcohol, Tranquilizers, Sleeping Pills, Inhalants
- ___ STIMULANTS: Cocaine, Crack, Crank, Speed, Diet Pills
- ___ STIMULANTS: Caffeine, Nicotine
- ___ NARCOTICS: Heroin, Codeine, Morphine
- ___ HALLUCINOGENS: LSD/Acid, PCP, Peyote, Shrooms
- ___ CANNABIS: Marijuana/Pot/Weed
- ___ OTHER: _____

When did you first use? _____ When did you last use? _____

SUICIDE/HOMICIDE: Have you ever had, or do you currently have:

	<u>Past</u>	<u>Now</u>
Thoughts of hurting yourself	_____	_____
Thoughts of committing suicide	_____	_____
Plans to commit suicide	_____	_____
Threats to commit suicide	_____	_____
Attempts to commit suicide	_____	_____
Thoughts of harming someone	_____	_____
Threats to harm someone	_____	_____
Plans to harm someone	_____	_____
Attempts to harm someone	_____	_____
Actually harmed someone	_____	_____

DEPRESSION: Have you ever, or do you now have:

	<u>Past</u>	<u>Now</u>
Inability to sleep/sleep longer (please circle) _____		
Increase/Decreased appetite (please circle) _____		
Tearfulness/feelings of despair _____		
Lack of energy or feelings of fatigue _____		
Preoccupation with life events? Please list: _____		

Decreased contact with others _____		
Personal feelings of depression _____		
Decreased interest in pleasurable activities _____		

PLEASE LIST ANY OTHER INFORMATION THAT YOU BELIEVE WILL BE HELPFUL FOR YOUR
COUNSELOR TO
KNOW _____

