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Licensed Clinical Psychologists
Using Research-Supported Therapies to Enrich Families

Adult History Form

Client's Name: _____ Today's Date:_____

Date of Birth: _____ Client's age when form completed_____

If person completing the form is different from client, write name and relationship to client:

_____

What is the client's marital status (e.g., single, divorced, widowed, etc.) _____

What are your current concerns and/or what prompted you to seek services?

When did you first notice the concerns listed above?

Who currently lives with the client?

Name	Age	Relationship to client	Occupation or grade in school	Highest grade completed in school (e.g., 1-12, Bachelor's, Master's, etc.)

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Education/Work History

What is the highest grade level completed by the client (e.g., 10th grade, Associate's Degree, Bachelor's Degree, Master's Degree, etc.)? _____

Is the client currently employed (check)? ☐ Yes / ☐ No

Full time or part time (check)? ☐ Full time / ☐ Part time

Current place of employment: _____

Current job title: _____

Health History

Who is the client's primary care physician? _____

Date of last visit to primary care physician: _____

Reason for most recent visit to primary care physician (e.g., physical exam, illness, etc.)

_____

Does the client have any chronic health concerns (list below)? If so, what is the current treatment?

Does the client have a history of (check if applicable and explain below):

Allergies		Respiratory Disease	
Cancer		Seizures	
Diabetes		Sleep Problems	
Emergency Department Visits		Stroke	
Headaches		Surgery	
Head injury		Vision problems	
Hearing problems		Other:	
Heart problems		Other:	
Hospitalizations		Other:	
Loss of consciousness		Other:	

Please explain any checked responses above:

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Mental Health History

Has the client been diagnosed with any of the following?

	Who diagnosed this?	When diagnosed (month/year)?
Alcoholism		
Anxiety: General Social Phobias		
Autistic Spectrum Disorder: Autism Asperger's Disorder Pervasive Developmental Disorder—PDD		
Antisocial Personality Disorder		
Attention Deficit Hyperactivity Disorder (ADHD)		
Bipolar Disorder		
Borderline Personality Disorder		
Depression		
Developmental Delay		
Drug Addiction		
Eating Disorder: Anorexia Bulimia		
Obsessive Compulsive Disorder (OCD)		
Oppositional Defiant Disorder		
Posttraumatic Stress Disorder (PTSD)		
Schizophrenia or other psychotic illness		
Other (explain):		

Has the client ever undergone a psychological, neuropsychological, educational or psychiatric evaluation or testing? Yes ☐ No ☐ (Please bring a copy of previous reports to evaluation.)

Have any of the following occurred in the client's history?
(Specify **P** if past concern; **C** if current concern; **N/A** if it has never been a concern)

	P, C, or N/A
Received treatment for drug or alcohol addiction?	
Abused medication or drugs?	
Injured self (cut, burn, pick at scabs/wounds) on purpose?	
Attempted suicide?	
Been arrested or had legal trouble?	
Been hospitalized due to mental health concerns?	
Thought about suicide or wanting to be dead?	
Threatened to hurt other people?	
Been the victim of violence or aggression?	
Been physically, emotionally or sexually abused?	
Been involved in a serious accident?	

Additional Details may be provided on the next page……

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Mental Health History Details:

Previous mental health treatment/therapy (including psychiatric hospitalizations, outpatient therapy, biofeedback, etc.):

Type of Treatment (e.g., psychological, psychiatric) & Location	Setting (outpatient clinic, hospital, intensive outpatient program, day treatment, residential treatment)	Dates of treatment	Length of treatment	Name of treating professional

Medications

List medication (besides antibiotics) that the client has taken or currently takes. Please list most recent/current medications first.

Medication	Dose	Date started	Date stopped	Prescribed by:	Treating what?

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Family Mental Health History

Does anyone in the client's family have a history of the following mental health concerns? If "yes," please specify how the person was related to the client using the following key:
M: mother; **F**: father; **C**: child; **S**: sibling;
MGF: maternal grandfather; **MGM:** maternal grandmother;
PGF: paternal grandfather; **PGM**: paternal grandmother;
A: Aunt; **U:** Uncle; **Cou:** Cousin; **N:** Niece or Nephew

Diagnosis	Yes	No	Specify all family members that apply:
Alcoholism/Alcohol Abuse	○	○	
Anorexia	○	○	
Antisocial Personality Disorder	○	○	
Anxiety	○	○	
Asperger's Disorder	○	○	
Autism	○	○	
Attention Deficit Hyperactivity Disorder (ADHD)	○	○	
Bipolar Disorder	○	○	
Borderline Personality Disorder	○	○	
Bulimia	○	○	
Conduct Disorder	○	○	
Depression	○	○	
Developmental Delay	○	○	
Obsessive Compulsive Disorder (OCD)	○	○	
Oppositional Defiant Disorder	○	○	
Schizophrenia or psychotic disorder	○	○	
Tic Disorder	○	○	
Other (explain):	○	○	

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Life Events

Have any of the following things occurred?

	Yes	No	When (month/year):	Explain briefly:
Caretaker for loved one:	○	○		
Child's chronic illness:	○	○		
Death of loved one:	○	○		
Divorce/separation:	○	○		
Financial Difficulties:	○	○		
Job Loss:	○	○		
Move:	○	○		
Other stressful life events (explain):	○	○		
Other stressful life events (explain):	○	○		

Do you have any other concerns that have not been addressed?