25109 Detroit Road #335

Westlake, OH 44145

Adult Client History

NAME: _____ D.O.B._____AGE:____

ADDRESS:_____
Street Apt. City State Zip

HOME PHONE#:_____WORK #:_____OCCUPATION:_____

REFERRED BY:_____RELATIONSHIP STATUS:_____

EDUCATION: _____

Reason(s) for seeking counseling:_____

_____

_____

Have you ever considered suicide? YES ( ) NO ( )
Have you ever attempted suicide? YES ( ) NO ( )
If yes, please explain when, where, how and treatment received (if any):_____

_____

_____

Please check off any life area listed below with which you currently have a concern:

___alcohol/drugs	**___body image**	**___children**	**___eating/food**
___education	**___family**	**___financial**	**___health**
___infertility	**___intimacy**	**___legal**	**___occupation**
___parenting	**___recreation**	**___spirituality**	**___other**

Please briefly explain: _____

_____

_____

SOCIAL HISTORY:

Partner (indicate yes/no – do not name)_____ **D.O.B:**_____**AGE:**_____

Occupation:_____**Length of relationship:**_____

Partner's general health:_____

Relationship concerns:_____

PREVIOUS RELATIONSHIPS (MARRIED OR COMMITTED):

Length of Relationship **Reason for Breakup**

Children: (indicate biological, adopted, foster, step, guardianship - first names only):

Reproductive History: (miscarriage, ectopic, termination)_____

FAMILY HISTORY:

Mother's status: (living/deceased) _____**Age** (if deceased please explain)_____

General health

Father's status: (living/deceased) _____**Age** (if deceased please explain)_____

General health

Siblings (in birth order, first name only please) **Age** **General Health**

Please answer the following questions with your most appropriate response:

Have you ever been physically, sexually or emotionally abused? (If yes please explain)____

Are you sexually active?_____

Are you practicing safe sex?_____

Have you ever been arrested or had legal action taken against you? (If yes, please explain)

Family Physician:_____**Phone #:**_____**Date of last exam:**_____

Height:_____**Current weight:**_____**Activity Level:**_____

==========

Have you ever used or do you currently use any of the following?

	Yes	No	Frequency	Date last used
Tobacco				
Alcohol				
Coffee				
Caffeinated soda				
Marijuana				
Cocaine				
Barbituates				
Heroin				
	Yes	**No**	**Frequency**	**Date last used**

Amphetamines
Hallucinogens
Tranquilizers
Anti-depressants
PCP
Inhalants
Other (please name)

PAST MEDICAL HISTORY:

Please list any significant illness/injury (date and treatment):

PAST MENTAL HEALTH HISTORY: (Including hospitalizations/12 step/self help):

Date	Therapist/Dr.	Location	Duration	Reason

Please add any additional information you consider important: (e.g. infertility treatment)

Signature: **Date:**

Name (please print):