A · C · F
ADULT CHILD FAMILY
COUNSELING OF MASON

PERSONAL DATA – ADULT

Personal Information

Name (First, MI, Last)		**Date**	
Address	**City**	**State**	**Zip Code**
Other Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**
( )	( )	( )

Where may we contact you?
☐ Home Phone ☐ Work Phone ☐ Cell Phone
☐ Address ☐ Other Address

Where may we leave a message?
☐ Home Phone ☐ Work Phone ☐ Cell Phone
☐ Other:

Age	**Date of Birth** (MM / DD / YYYY)	**Social Security Number**	**Marital Status**	**Gender**
			☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widow ☐ Other	☐ Male ☐ Female

Spouse / Partner Information

Spouse / Partner Name ☐ No Spouse / Partner				**Contact Phone** ( )
Age	**Date of Birth** (MM / DD / YYYY)	**Quality of Relationship**	**Previously Married?** ☐ Yes ☐ No	**Spouse / Partner Involved in Therapy?** ☐ Yes ☐ No

Emergency Contact Information

Emergency Contact Person	**Contact Phone** ( )
Relationship to Client	**May we leave a message?** ☐ Yes ☐ No

Impairments & Limitations

Do you have any physical impairments or limitations, which may require special accommodations, arrangements, or may affect your treatment (e.g., reading difficulties, hearing/vision/speech impairment)?
☐ No ☐ Yes, Explain:

Education History

Education (check all that apply)
☐ GED ☐ HS Grad ☐ Vocational ☐ Undergraduate ☐ Graduate ☐ Professional ☐ Other

Employment Information

Current Employer ☐ No Employer / Unemployed			**Hours/Week**
☐ Full-time ☐ Part-time ☐ Student ☐ Disabled ☐ Volunteer ☐ Retired ☐ Homemaker ☐ Other			
Occupation	**Length of Employment** Months _____ Years _____		**Phone Number** ( )
Spouse / Partner Occupation	**Length of Employment** Months _____ Years _____		**Phone Number** ( )

Living Situation

My Living Situation:

Household Member Names	Relationship	Age	Quality of Relationship

Family History

Parents' Names:		
Siblings' Names/Ages:		
Concerns about Family Members, Describe:		

Military History / Information

☐ None
☐ V.A. Benefits
☐ Career Benefits
☐ Combat History

Branch of Service:	**Rank / Grade**	**Years of Service**

Date of Discharge (MM / YYYY)	**Type of Discharge** (general, honorable, etc.)

Religious History

Religious History
Affiliated with group? ☐ Yes ☐ No

Importance of Spiritual Matters
☐ Not at all ☐ A little ☐ Moderate ☐ Much

Religious Affiliation/Denomination

Current Situation

In general, why are you seeking services at this time? (select all that apply)

☐ Family Problems ☐ Work Problems ☐ Excessive Anger ☐ Depression ☐ Anxiety
☐ Alcohol/Drugs ☐ Uncertain ☐ Other:

Describe:

Client ID:

Stress events or loss in last six months? ☐ No ☐ Yes, explain:

Difficulty with Activities of Daily Living: (select all that apply)

☐ None	☐ Dressing	☐ Homemaking	☐ Shopping
☐ Budgeting	☐ Mobility	☐ Transportation	☐ Communication
☐ Parenting	☐ Leisure Time	☐ Time Management	☐ Stress Management
☐ Grooming/Hygiene	☐ Other:		

Describe:

Medical History / Information

Physical Health:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	**Height**	**Weight**

Physical Health Problems? ☐ No ☐ Yes, describe:

Drug/Food Allergies? ☐ No ☐ Yes, describe:

Appetite changes in last six months? ☐ No ☐ Yes, describe:

Weight loss/gain in last six months? ☐ No ☐ Yes, describe:

Describe the nutritional value/balance of your diet: ☐ Good ☐ Fair ☐ Poor

How many hours do you sleep in a typical 24-hour period?

Are you having problems with your sexual functioning? ☐ No ☐ Yes, describe:

Have you taken mediation for a mental health condition? ☐ No ☐ Yes, describe:

Serious Illnesses, Accidents, Operations (issue/side effects/etc.) ☐ No ☐ Yes, describe:

Risk of Harm

Past Attempts to Harm Self or Others ☐ None ☐ Self ☐ Others ☐ Property
Comments: ☐ No Comments

Current Risk of Harm to <u>SELF</u> ☐ None
Comments: ☐ No Comments

Current Risk of Harm to <u>OTHERS</u> ☐ None
Comments: ☐ No Comments

Client ID:

Other Considerations

Have you experienced any of the following? ☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse
If yes, describe: ☐ Sexual Assault/Rape ☐ Domestic Violence ☐ Other Trauma

Cultural/Ethnic/Racial issues that need consideration? ☐ No ☐ Yes, describe:

Religious/Spiritual issues that need consideration? ☐ No ☐ Yes, describe:

Sexual orientation issues that need consideration? ☐ No ☐ Yes, describe:

Select Current Behaviors and Symptoms (select all that apply)

☐ Aggression	☐ Eating Disorder	☐ Memory Impairment	☐ Sick Often
☐ Alcohol Abuse/Dependence	☐ Elevated Mood	☐ Mood Shifts	☐ Sleeping Problems
☐ Anger	☐ Fatigue	☐ Panic Attacks	☐ Suicidal Thoughts
☐ Antisocial Behavior	☐ Feeling Stressed/Overwhelmed	☐ Perfectionism	☐ Test/Performance Anxiety
☐ Anxiety	☐ Financial Concerns	☐ Phobias / Fears	☐ Thoughts Disorganized
☐ Avoiding People	☐ Gambling	☐ Problems with School/Work	☐ Trembling
☐ Changes in Appetite	☐ Grief/Loss	☐ Procrastination	☐ Trouble with Career Decisions
☐ Chest Pain	☐ Hallucinations	☐ Reading/Study Skills Problems	☐ Withdrawal
☐ Cyber-Addiction	☐ Heart Palpitations	☐ Recurring Thoughts	☐ Worrying
☐ Depression	☐ High Blood Pressure	☐ Relationship Difficulty	
☐ Difficulty Adjusting to Change	☐ Homesickness	☐ Religious/Spiritual Concerns	☐ Other:
☐ Difficulty Concentrating	☐ Hopelessness	☐ Self-Esteem Difficulties	
☐ Disorientation	☐ Impulsivity	☐ Self-injury(cutting, burning, etc)	
☐ Distractibility	☐ Irritability	☐ Sexual Addiction	☐ Other:
☐ Dizziness	☐ Judgment Errors	☐ Sexual Difficulties/Concerns	
☐ Drug Abuse/Dependence	☐ Loneliness	☐ Shyness	

Current / Previous Medication Information

☐ None **List all current medications, as well as those used within past 5-7 years** (prescription / OTC / herbal)

Medication	Rationale	Dosage / Frequency	Current?	Compliance		
				Yes	No	Partial
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			
			☐ Yes ☐ No			

Primary Care/Physician Information

Primary Care Physician (include name, phone no., and address)
☐ None

Date of Last Exam (MM / DD / YYYY)
☐ Unknown

Psychiatrist
☐ None

Other Prescribing Physician(s)
☐ None

Client ID:

Mental Health Treatment History

Outpatient Mental Health Treatment ☐ None

Agency Name	Current?	Past (Date)	Therapist Name
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Psychiatric Hospitalizations ☐ None

Hospital Name	Date of Service	Reason (suicidal, depression, etc.)

Previous or Current Diagnoses (if known)

☐ Not Known

Reason(s) for Discontinuation

☐ No Comments

What did you Find Least/Most Helpful About Past Treatment?

☐ No Comments

Other Comments Regarding Mental Health Treatment History

☐ No Comments

Alcohol / Drug History

☐ None	Tobacco	☐ Yes ☐ No ☐ Past Use Packs per Day:
	Alcohol Use	☐ Yes ☐ No ☐ Past Use If Yes, Check One: ☐ Occasional ☐ 1x Per Week ☐ More than 1x Per Week
	Other Substances	☐ Yes ☐ No ☐ Past Use

Have you ever had concerns about your use of alcohol, prescription medication, or other drugs? ☐ Yes ☐ No

Has anyone else ever expressed concerns about your use of alcohol, prescription medication, or other drugs? ☐ Yes ☐ No

Have you ever tried to cut down or quit using alcohol or other drugs? ☐ Yes ☐ No

Is there a history of substance abuse problems in your family? ☐ Yes ☐ No

Have you ever experienced any of the following in connection with your use of alcohol, drugs, or prescription medications?

If yes, check all that apply. ☐ Yes ☐ No

☐ Work Problems ☐ Financial Problems ☐ Blackouts ☐ Withdrawal Symptoms ☐ Relationship Problems
☐ Increased Tolerance ☐ Physical Problems ☐ Cravings ☐ Emotional Problems

Client ID:

Drugs / Substances / Alcohol / Tobacco

Substance Name	Age of 1st Use	Date of Last Use	Frequency of Use	Amount	Method

Alcohol / Drug Treatment History

☐ None

Current Alcohol/Drug Status: ☐ OP ☐ IOP ☐ Residential ☐ Other

Past Alcohol/Drug Status: ☐ OP ☐ IOP ☐ Residential ☐ Hospital ☐ Detox ☐ Other

☐ None

Treatment Facility Information If current or past complete the following:

Name of Agency	Type of Service	Date of Service

Other Addictive Behaviors

☐ None

Legal History

Current Legal Status (select all that apply)

☐ None ☐ On Probation ☐ Detention ☐ On Parole ☐ Awaiting Charge

☐ AoD Legal Problems ☐ Conditional Release ☐ OP Commitment ☐ Court-Order Treatment

History of Legal Charges (if so, please describe)

☐ None

Referral Information

How did you find out about our Counseling Center? (select all that apply)

☐ Friend ☐ Website ☐ Doctor ☐ Mental Health Professional ☐ School ☐ Court ☐ Minister ☐ Other:

Please describe:

Signatures

Client Signature	**Date** (MM / DD / YYYY)
Therapist Signature	**Date** (MM / DD / YYYY)
Supervisor Signature	**Date** (MM / DD / YYYY)

Client ID: