FREMOUW SIGLEY & BAKER PSYCHOLOGICAL ASSOCIATES PLLC

Adult Information Form

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CLIENT INFORMATION

Name:____ Date:____________________________________
Birth Date:___________________ Address:____
City:______________________________ State:______________________ Zip:_____________________
Phone:____________________ Cell: ____________________ Next of Kin:_________________________
Relationship:__________________________________ Phone of Kin:_____________________________
Address of Kin:____

HEALTH INSURANCE INFORMATION

Primary Care Physician Name:____
Name of Policy Holder:___________________________ Birth Date of Policy Holder:___________________
Address of Policy Holder:____
Sex of Policy Holder: M____ F____ Relationship to Policy Holder: Self____ Spouse____ Child____ Other____
Insurance Company Name:____
Insurance Mailing Address:____
ID Number:________________ Group Number:_______________ Ins Co Phone:____________________
Employer:_______________________ Ins. Phone Number for Mental Health:________________________
Is there another health benefit plan? Yes ________________ No______________ If yes, please provide:
Name of Other Insured:___________________________________ Date of Birth:____________________
Other Insurance Company Name:____

CONTACT INFORMATION AND PERMISSION

Email:____
I authorize: (Please indicate YES or NO for each option)

YES NO Leave a message on my home answering machine
YES NO Leave a message on my work voicemail
YES NO Leave a message on my cell phone voicemail
YES NO Leave a message with a family member/friend at my home
Only the following:________________________________
YES NO Contact me by mail at the following address (to include billing):

BASIC BACKGROUND INFORMATION OF CLIENT

☐ I received an informed consent form and was given the opportunity to ask questions.
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐Widowed ☐ Separated ☐ Other ☐N/A
Spouse/Partner's First/Last Name:____
Children (First name, age):____
Religious Affiliation:____
Military history of client or immediate family members:____
Persons living in my home:____
Education (highest grade completed):________ School:____________________ Current Grades:___________

What type of work do you do?____
How long?______________________ Employer:____

DEMOGRAPHIC INFORMATION OF CLIENT

What is your birth gender? Male___ Female___ How would you categorize your gender?__________________
How would you categorize your affectional orientation? _______________ Preferred Pronouns:_____________
How would you categorize your racial identity?____
How would you categorize your ethnic identity?____

YOUR COUNSELIING HISTORY, NEEDS, AND GOALS

What is your most pressing reason for seeking counseling?____
____
What are your other concerns?____
How did you find out about our practice? ☐ Website ☐ Search Engine ☐ Friend
Is counseling or evaluation requested? ☐ Evaluation ☐ Counseling
Please tell me about your previous counseling experiences:

Provider	Where	When	How long	Useful? Y/N

Are you currently having suicidal thoughts? ☐ Yes ☐No
If yes, please describe:____
Have you ever made a suicide attempt? ☐ Yes ☐No When?_____________________________________
If yes, please explain:____
Has anyone related to you ever attempted suicide? ☐ Yes ☐No or completed suicide? ☐ Yes ☐No
If yes, please explain:____
Are you currently having homicidal thoughts? ☐ Yes ☐No
If yes, please explain:____
Have you or anyone related to you attempted a homicide? ☐ Yes ☐No When?________________________
If yes, please explain:____
Do you worry about your safety in your current living situation? ☐ Yes ☐No
If yes, please explain:____
Have you ever struck or threatened people or animals or broken things in your home? ☐ Yes ☐No
If yes, please tell me about it:____
Have you engaged in any self-injurious behavior? ☐ Yes ☐No
If yes, please explain:____

What are your strengths? (check all that apply)

☐ Bright	☐ Insightful	☐ Motivated	☐ Active
☐ Have self-control	☐ Have friends	☐ Can calm myself	☐ Mostly healthy
☐ Can ask for help	☐ Keep my boundaries	☐ Have moral ethics	☐ Can solve problems
☐ Can forgive	☐ Can express feelings	☐ Stable employment	☐ Resourceful
☐ Sense of humor	☐ Compassionate	☐ Patient	☐ Good listener
☐ Have enough money to meet my needs	☐ Satisfied with employment	☐ Willing to learn new attitudes and behaviors	☐ Can accept love and care from others

CLIENT SOCIAL HISTORY

How many times have you been married and for how long? ____
Please describe your relationship with your mother: ____
Father:____
Step parent(s):____
Please list significant traumatic events or losses: ____
Please list brothers and sisters and their ages:____
Please describe any significant legal history (i.e. arrest, bankruptcy):__________________________________
____
____
Is there anything else significant that you want me to know?_______________________________________
____
____

CURRENT SYMPTOMS

Current symptoms: (Please check all that apply and add details you believe are relevant in the blanks.)

- ☐ Depression: ______________________________
- ☐ Sleep changes: ___________________________
- ☐ Appetite changes: _________________________
- ☐ Crying: _________________________________
- ☐ Energy level: _____________________________
- ☐ Weight change: ___________________________
- ☐ Odd beliefs: ______________________________
- ☐ Memory problems: _________________________
- ☐ Pain: ___________________________________
- ☐ Thoughts to harm others: __________________
- ☐ Irritability: _______________________________
- ☐ Confusion: _______________________________
- ☐ Anxiety: _________________________________
- ☐ Anger Problem: ___________________________
- ☐ Impulsivity: ______________________________
- ☐ Violent behavior: __________________________
- ☐ School problems: __________________________
- ☐ Panic attacks: _____________________________
- ☐ Self-injuries: ______________________________
- ☐ Racing thoughts: ___________________________
- ☐ Hearing voices: ____________________________
- ☐ Poor concentration: _________________________
- ☐ Seeing things: _____________________________
- ☐ Paranoia: _________________________________
- ☐ Suicidal thoughts: __________________________
- ☐ Avoiding people/places: _____________________
- ☐ Preoccupations/rituals: ______________________
- ☐ Running away: _____________________________
- ☐ Sexual problems: ___________________________
- ☐ Mood swings: ______________________________
- ☐ Loss of pleasure: ___________________________
- ☐ Other: ____________________________________

MEDICAL HISTORY

Family Physician:______________________________ Date of last physical examination:_________________

Please check any illness client currently has or has had in the past:

☐ Diabetes	☐ High blood pressure	☐ Lung disease	☐ Venereal Disease
☐ Asthma	☐ Low blood pressure	☐ Cancer	☐ Head injuries
☐ Arthritis	☐ Heart disease	☐ Kidney disease	☐ Injuries
☐ Anemia	☐ Tuberculosis	☐ Cirrhosis	☐ Muscular Disorder
☐ Ulcers	☐ Colitis	☐ Bone disorder	☐ Obesity
☐ Seizures	☐ Nerve disorder	☐ Anorexia	☐ HIV/AIDS
☐ Alcohol/drug problems	☐ Migraines	☐ Urinary Tract Infection	☐ Headaches
☐ Constipation	☐ Thyroid issues	☐ Surgeries:	

Is there any history of depression, mental illness, or alcohol/drug problems in your family of origin?
☐ Yes ☐ No If yes, please explain:____
____

Do you have any history of depression, anxiety, or mental illness? ☐ Yes ☐ No
If yes, please explain:____
____

Please tell me about past hospitalizations (include psychiatric or substance abuse treatment):

Date	Reason	Hospital	Physician

Are you taking any medications now? ☐ Yes ☐ No If yes, please list: _____________________________
Do you use nicotine? ☐ Yes ☐ No Type:____
How much caffeine do you consume?
Estimated daily consumption of coffee or tea: ______________ cups/day
Estimated daily consumption of soda or pop: ______________ ounces/day

SUBSTANCE USE INFORMATION

Do you have a history of IV drug use? ☐ Yes ☐ No; Marijuana? ☐ Yes ☐ No; Pills? ☐ Yes ☐ No
List others:____
Any use of these substances in the last year? ☐ Yes ☐ No Please list:_____________________________
Have you ever felt the need to cut down on substance consumption? ☐ Yes ☐ No
Have people annoyed you by criticizing your substance use habits? ☐ Yes ☐ No
Do you have cravings or urges to use illicit substances? ☐ Yes ☐ No
Has your substance use caused difficulties to attend school/work? ☐ Yes ☐ No
Have you experienced withdrawal symptoms when not using substances (e.g. Irritability, depression, anxiety, shakiness, nausea, vomiting, insomnia, restlessness)? ☐ Yes ☐ No
Have you ever needed a drink first thing in the morning (eye-opener) to steady nerves or to get rid of a hangover? ☐ Yes ☐ No
Do you drink alcohol socially? ☐ Yes ☐ No If yes, how often?______________ How much?_____________
How old were you when the first use of identified substances were consumed? _________________________
Have you ever attended: ☐ A.A. ☐ Alanon ☐ Narcotics Anonymous
Ever had a D.U.I? ☐ Yes ☐ No If yes, how many?____________
Have you ever been arrested for a drinking or drug related offense of any kind? ☐ Yes ☐ No
If yes, please explain:____

CLIENT SIGNATURE

Signature of the client or authorized person allows release of information necessary to process insurance claims and authorizes direct payment of health insurance benefits to Fremouw, Sigley & Baker Psychological Associates. THIS INFORMATION WILL INCLUDE DIAGNOSIS, DATES OF TREATMENT, AND SOMETIMES TREATMENT PLAN.

_______________________________________ _______________________________________
Client Signature Date